STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of [redacted] Pursuant to § 494 of the Social Services Law	**FINAL DETERMINATION AND ORDER AFTER HEARING** **Adjud. Case #s:** [redacted]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

This decision is ordered by Elizabeth M. Devane, ALJ, of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: January 29, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Robert DeCataldo, Esq.
[redacted], Subject
Christopher Przespo, Esq.

STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #s: [redacted]

Before: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
2165 Brighton Henrietta Town Line Road
Rochester, New York 14623
On: [redacted]

Parties: New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Robert DeCataldo, Esq.

[redacted]
By: Christopher Przespo, Esq.
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains two separate "substantiated" reports, dated [redacted], of neglect by the Subject of Service Recipient A[1] under [redacted] and Service Recipient B[2] under [redacted].

2. The Justice Center substantiated the two reports against the Subject. The Justice Center concluded that:

Allegation 1 – [redacted] (Report #1)

It was alleged that on [redacted], at the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide proper supervision to a service recipient.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law §493(4)(c).

Allegation 1 - [redacted] (Report #2)

It was alleged that on [redacted], at the [redacted], located at [redacted]

[1] Service Recipient A is the disabled individual involved in the alleged [redacted] incident regarding a Hoyer lift under Report #1 - [redacted].

[2] Service Recipient B is the disabled individual involved in the alleged [redacted] incident regarding being left in a tub under Report #2 - [redacted].

[redacted], while a custodian, you committed neglect when you failed to provide proper supervision to a service recipient, during which time he was left unattended in the bathtub.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law §493(4)(b).

3. An Administrative Review was conducted and as a result the substantiated report was retained.

4. The facility, located at [redacted], is a facility for disabled individuals, and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. At the time of the alleged incidents, there were ten service recipients who resided at the facility and three staff persons working the evening shift. (Hearing testimony of Justice Center Investigator 1[3] and Justice Center Investigator 2[4] in Report #1 - [redacted] and Justice Center Investigator A[5] in [redacted]; Justice Center Exhibits 5 of [redacted] and [redacted])

5. At the time of the alleged neglect, the Subject had been employed at the facility for approximately ten years as a Direct Support Assistant (DSA). However, as of [redacted], the Subject was employed in her new role as a Developmental Assistant Trainee (DAT) 1 and she usually worked the [redacted] shift. On [redacted], the Subject was assigned to

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[3] [redacted] is hereinafter referred to as Justice Center Investigator 1 for Report #1 under [redacted] and was the lead investigator.

[4] [redacted] is the Justice Center Investigator that testified in regard to both substantiated reports. He is hereinafter referred to as Justice Center Investigator 2 for Report #1 under [redacted] and was the lead investigator in regard to Report #2 under [redacted])

[5] Refer to footnote 2 supra.

supervise and care for Service Recipient A. On [redacted], the Subject was assigned to supervise and care for Service Recipient B. The Subject was familiar with both of the Service Recipients and their treatment plans. On [redacted] and [redacted], the Subject was working with the facility supervisor (DA 1)[6] and Staff 1[7]. The Subject was a custodian to both of the Service Recipients as that term is so defined in Social Services Law § 488(2). (Hearing testimony of the Subject, Justice Center Investigator 1 and Justice Center Investigator 2; Justice Center Exhibits 5 of Report #1 - [redacted] and Report #2 - [redacted])

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to both substantiated reports.
- Whether the substantiated allegations in both substantiated reports constitute neglect.
- Pursuant to Social Services Law § 493(4), the category of neglect that such act or acts constitute in regard to both substantiated reports.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

[6] [redacted] is hereinafter referred to as the DA 1, a lower level supervisor at the facility.
[7] [redacted] is hereinafter referred to as Staff 1.

The neglect of a person in a facility or provider agency is defined by SSL § 488(1) (h) as:

> "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Categories 2 and 3, which are respectively defined under SSL § 493(4)(b) and (c) as follows:

> Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.
>
> Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of neglect alleged in the two substantiated reports that are the subject of the proceeding and that such act or acts constitute the category of neglect as set forth in the substantiated reports. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged neglect, the report(s) will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of neglect cited in the substantiated report(s) constitutes the category of neglect as set forth in the substantiated report(s).

If the Justice Center did not prove the neglect by a preponderance of the evidence, the substantiated report(s) must be amended and sealed.

Findings of Fact for Report #1 (Service Recipient A)
Allegation 1 of [redacted]
(Date of Incident [redacted])

6. At the time of the alleged neglect on [redacted], Service Recipient A[8] was a non-verbal male who was approximately fifty-six years old. He used a manual wheelchair to get from one place to another. Service Recipient A communicated by laughing and making facial expressions while relying on staff to anticipate his wants and needs. He had the capability to reach over to touch someone or reach for nearby objects on which to chew, such as a cloth, hard rubber items or hand towels. Staff guidelines have been implemented to address his occasional incidents of "mouthing" objects. Service Recipient A had diagnoses of severe intellectual disabilities, seizure disorder (epilepsy), hyperthermia, PICA, osteoporosis and other medical conditions. (Hearing testimonies of Justice Center Investigator 1 and Justice Center Investigator 2 for Report #1 - [redacted]; Justice Center Exhibits 5 - Case Summary Report, 6 - Individual Protective Oversight Plan (IPOP) dated [redacted] and 7 of Report #1 - [redacted])

7. According to Service Recipient A's treatment plans, his [redacted] Individual Service Plan (ISP) (Justice Center Exhibit - 7 of Report #1 - [redacted]) stated that,

[8] Service Recipient A was the disabled individual involved in the [redacted] incident regarding Report #1 under [redacted].

while in the residence during waking hours, Service Recipient A required periodic observations every thirty minutes and that he cannot be left without clothes for extensive periods of time because he suffers from episodes of hypothermia[9], a medical condition for which cold weather guidelines had been developed to ensure that he was properly dressed to prevent hypothermia. Service Recipient A's ISP and IPOP further required two staff persons to use a mechanical (Hoyer) lift for all transfers from toilet/showers and chair/bed. During the overnight hours, staff were required to conduct thirty-minute visual checks for signs of life and hypothermia. In addition, his IPOP and ISP provided that while Service Recipient A utilized his manual wheelchair for mobility, a "pelvic belt and chest strap" was required to be applied while he was in his wheelchair "to maintain alignment with the seating system." (Justice Center Exhibit 6 - IPOP at pages 1 - 2 and Justice Center Exhibit 7, ISP - "Safeguards" section at page 2 of Report #1 - [redacted])

8. Sometime between 7:35 p.m. and 8:15 p.m. in the evening of [redacted], while in the bathroom, the Subject began to prepare Service Recipient A for his shower. The Subject removed all of his clothes except his attend's brief. At some point, the Subject had adjusted Service Recipient A's wheelchair to a reclined position. As Service Recipient A remained seated in his reclined wheelchair, he was uncovered and unclothed. The Subject then positioned the Hoyer's sling-seat underneath the back side of Service Recipient A's body. After the Subject connected the sling-seat to the mechanical lift, a portion of his body (thighs and legs) was slightly suspended over the wheelchair seat but his bottom remained seated in the wheelchair. The Subject, however, did not affix Service Recipient A's pelvic belt and chest strap that was required for

[9] "Hypothermia develops when your body temperature drops too low. Your body can't keep itself warm enough and starts to shut down…the conditions don't have to be extreme – an infant or an older person can get hypothermia inside if they're in a chilly room for too long. Alcohol, mental illness and other conditions increase the risk. Hypothermia needs medical attention right away. Untreated, it can be deadly." Refer to WebMD for definition of Hypothermia.

alignment and safety purposes when he is seated in his wheelchair. (Hearing testimony of the Subject; Justice Center Exhibits 6 - 7, 15, 20 - audio of the DA 1's interview and 21 - written transcript of the DA 1's interview at lines 2 through 15 on page 4 of Report #1 - [redacted]) The Subject then left Service Recipient A to find a second staff person to assist her with the Hoyer lift because two staff persons were required to safely transfer Service Recipient A from his wheelchair to the shower-chair. The Subject asked for assistance from her co-workers who were both in the medication room, but no one came immediately to assist her with Service Recipient A's Hoyer lift. (Hearing testimony of the Subject) While waiting for a co-worker's assistance with the Hoyer lift, the Subject left Service Recipient A in the room in that same position in his wheelchair for about thirty minutes. When the Subject left Service Recipient A alone, she went to a different area to assist another service recipient with toileting. (Hearing testimony of the Subject and Justice Center Investigator 1; Justice Center Exhibits 5 - 7, 13, 15, 20 and 21 of Report #1 - [redacted])

9. During the Subject's period of absence, Staff 1 noticed Service Recipient A alone in the bathroom and called the DA 1 down to where he was located. The DA 1 entered the room and discovered that Service Recipient A had been left there unsupervised by the Subject and that he was wearing no clothes other than his attends brief. She further saw that Service Recipient A was in his wheelchair in a tilted position with his bottom in the seat and the Hoyer lift's sling-seat underneath him which slightly suspended his body (thighs or legs) in the air because it was connected to the mechanical lift. She also saw that Service Recipient A's adaptive equipment (pelvic belt and chest strap) for his wheelchair had not been affixed. The DA 1 then unhooked the Hoyer sling seat that was underneath Service Recipient A from the mechanical lift itself and moved the wheelchair into an upright position. The DA 1 checked Service Recipient A for injuries and

observed none. The DA 1 put a robe on Service Recipient A, covered him with a blanket and affixed his adaptive equipment to properly align and secure him in the wheelchair. (Hearing testimony of the Subject and Justice Center Investigator 1; Justice Center Exhibits 5 - Case Summary Report, 13 - Staff's Daily Notes, 17 – the DA 1's Body Check Form, 20 - audio of the DA - 1's interview and 21 - written transcript of the DA 1's interview at lines 6 through 22 at page 4 and lines 12 through 21 at page 5 of Report #1 - [redacted])

DISCUSSION FOR REPORT #1 – [redacted]
(Service Recipient A - Date of Incident [redacted])

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report under [redacted].

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1 - 22 of Report #1 - [redacted]) The investigation underlying the substantiated report was conducted by Justice Center Investigator 1 with assistance from Justice Center Investigator 2[10], who were the only witnessed who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and provided no other evidence.

During the Subject's investigatory interview and at the hearing, the Subject admitted that she left Service Recipient A unsupervised in his wheelchair for about thirty minutes to attend to another individual. The Subject testified that at the time of her absence, Service Recipient A had no clothes on, but was wearing his attends brief. She further explained that the Hoyer's sling seat was underneath Service Recipient A, but that it had not yet been connected to the mechanical lift

[10] As previously statement in footnote 4, supra, [redacted] testified in regard to both substantiated reports. He is hereinafter referred to as Justice Center Investigator 2 in regard to [redacted] (Report #1) and referred to as Justice Center Investigator A for [redacted] (Report #2).

itself. The Subject also testified that when she had exited the room, Service Recipient A's body was not suspended in the air at all and that he was seated down in his wheelchair with an unconnected Hoyer sling seat underneath him.

In addition, the Subject testified that the photographs do not accurately depict the manner in which she left Service Recipient A alone. (Justice Center Exhibit 14) The Subject explained that before she left the room, she had covered Service Recipient A with a blanket as he sat reclined in his wheelchair and that she had positioned a privacy screen to shield him from public view. She also stated that the DA 1 and Staff 1 were in the medication room and when she asked them for assistance with lifting Service Recipient A into the shower, the DA 1 said she was busy and slammed the door in her face. The Subject stated that she waited a long time with Service Recipient A for her co-workers to assist her with the Hoyer lift, but that no one came in a timely fashion, and that she left Service Recipient A in his wheelchair in order to accompany another service recipient to the bathroom. The Subject testified that finally at about 8:35 p.m. on [redacted], she called the Administrator on Duty (AOD) to inform him about her work situation. The Subject also stated that she had a difficult working relationship with the DA 1 in that no matter what she did the DA 1 felt it was never right. The Subject also stated that she had a bad work relationship with Staff 1 because she had reported what was going on at the house.

The Justice Center contends that the Subject failed to provide proper supervision to Service Recipient A and that her conduct was likely to cause injury or harm to Service Recipient A. The Justice Center argues that it was improper for the Subject to have left Service Recipient A alone, unstrapped as he sat in a reclined wheelchair, wearing no clothes with the Hoyer's sling seat underneath him that was connected to the mechanical lift which slightly elevated his body.

In order to prove neglect, the Justice Center must establish that the Subject breached a

custodian's duty and that such conduct resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of Service Recipient A. (SSL §488(1)(h))

In analyzing the evidence, during her hearing testimony, the Subject admitted that for about thirty minutes she left Service Recipient A unsupervised, reclined and seated in his wheelchair, wearing no clothes (only his brief) with the Hoyer sling seat underneath him. The Subject also admitted that that she did not affixed his pelvic belt and chest strap to secure him in his wheelchair. The Subject further testified that, before she left Service Recipient A, she covered him with a blanket and that the Justice Center's photographs did not accurately depict the manner in which she left Service Recipient A in his wheelchair. (Justice Center Exhibit 14 of Report #1 - [redacted]) The Subject denied that when she left Service Recipient A unsupervised that his body was suspended in the air and that the Hoyer sling seat underneath him was connected to the mechanical lift.

The DA 1's version of events as told to the investigator is similar to the Subject's but inconsistent only to the extent that the DA 1 saw Service Recipient A alone in his reclined wheelchair with a connected Hoyer sling underneath him that caused his body to be slightly suspended in the air. The DA 1 also told the investigator that Service Recipient A's body was exposed and not covered with a blanket. In addition, the investigator testified that during her investigatory interview, the DA 1 gave him the photographs (Justice Center Exhibit 14 of Report #1 - [redacted]) that she had taken that evening that depicted the manner in which she found Service Recipient A. (Hearing testimony of the Justice Center Investigator 1; Justice Center Exhibits 5 and 20 - 21 of Report #1 - [redacted])

Therefore, the dispute remains in regard to some of the details as to how the Subject left

Service Recipient A unsupervised and seated in his wheelchair.

After a careful review of the complete record, it is determined that the DA 1's account of the incident is deemed as credited evidence. The DA 1, a direct witness to the incident, provided a compelling, detailed, reliable and consistent version of the incident which she had documented in detail in the Daily Notes (Justice Center Exhibit 14 of Report #1 - [redacted]. Additionally, although the Subject claimed to have covered Service Recipient A with a blanket, she has admitted that, in spite of his hypothermia and seizure conditions, she left Service Recipient A unsupervised for about thirty minutes and without clothing, seated in a wheelchair without his pelvic belt and chest strap being affixed with the Hoyer lift sling seat underneath him.

The credible evidence establishes that for about thirty minutes, the Subject left Service Recipient A unsupervised, seated in his reclined wheelchair without his required pelvic belt and chest strap properly affixed to maintain his body alignment. While the Hoyer sling seat was connected to the mechanical lift, the Subject left the Hoyer sling seat underneath Service Recipient A's body which caused his body to be slightly elevated under his thighs and legs. The evidence also establishes that for a period of time, the Subject left Service Recipient A unclothed and uncovered with a blanket to keep him warm even though he suffers from episodes of hypothermia, a condition that could occur indoors under his circumstances. The Subject should have known this and, at least, should have covered him with a blanket or a robe to keep him warm and reduce any risk of hypothermia.

As a custodian, the Subject had a duty to follow Service Recipient A's treatment plans. However, the manner in which the Subject left Service Recipient A unsupervised was contrary to his treatment plans and as such constituted a breach of duty.

Although Service Recipient A did not suffer any physical injuries from the incident, the

Subject's conduct was likely to have resulted in physical injury, or serious or protracted impairment of the physical, mental or emotional condition of Service Recipient A. The fact that Service Recipient A was unclothed, and his body exposed a period of time (at least thirty minutes) placed him at a significant risk of hypothermia as specifically stated in his treatment plans. In addition, the Subject left Service Recipient A seated in his wheelchair in an awkward position with the Hoyer sling seat underneath him and with his thighs and legs slightly raised or suspended in the air. As he was left seated in his wheelchair, Service Recipient A was also without his adaptive equipment (pelvic belt and chest strap) that, according to his [redacted] IPOP (Justice Center Exhibit 6 of Report #1 - [redacted]), was needed to maintain his body alignment in the wheelchair. Given the awkward manner in which the Subject left Service Recipient A seated, the Subject created an increased risk of physical harm to Service Recipient A as he was not properly positioned or secured in the wheelchair, had a history of seizures and he was not being supervised to prevent him from reaching for objects to put in his mouth.

All of the Subject's defenses have been fully considered and have been found to either be unpersuasive or lack merit.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged on [redacted] in regard to Service Recipient A. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report.

Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report under [redacted] is properly categorized as a Category 3 act.

Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496 (2). The report will be sealed after five years.

Findings of Fact for Report #2
Allegation 1 of [redacted]
(Service Recipient B - Date of Incident [redacted])

10. At the time of the alleged neglect on [redacted], Service Recipient B[11] was approximately thirty years old and fully ambulatory. He was non-verbal, but his receptive communication is stronger than his expressive communication. He understands simple verbal cues and signs such as "sit" and "no" and he was able to communicate his wants and needs through his moods and will push items away or take items to show that he wants or does not want them. He has resided at the facility since [redacted] of 2011. Service Recipient B had diagnoses of a profound intellectual disability, autism, seizure disorder, self-injurious behavior (SIB) and other medical conditions. The facility has documented that Service Recipient B has a seizure once a year. (Justice Center Exhibits 5 and 6 - Individual Service Plan (ISP), 7 - Individual Protective Oversight Plan (IPOP) and 8 - Service Recipient B's Medication Monitoring Plan of Report #2 - [redacted])

11. According to Service Recipient B's Individual Protective Oversight Plan (IPOP), effective [redacted], while he bathes, Service Recipient B required a range of scanning (ROS) level of supervision. (Justice Center Exhibit 7 of Report #2 - [redacted]) However, Service Recipient B's Individual Service Plan (ISP) (Justice Center Exhibit 6 of Report #2 -

[11] Service Recipient B was the disabled individual involved in the [redacted] incident regarding Report #2 under [redacted].

[redacted]) dated [redacted] and reviewed on [redacted], contradicted his IPOP in that his ISP stated that Service Recipient B requires one to one (1:1) (or eyes on) supervision while he bathed due to his seizure disorder. (Justice Center Exhibit 6 of Report #2 - [redacted]) Service Recipient B's ISP further noted that he takes medication for seizure control and that seizure guidelines have been put in place for staff to follow to protect him from injury and reduce and/or maintain seizure activity. (Hearing testimony of the Justice Center Investigator; Justice Center Exhibits 5 - 7 of Report #2 - [redacted])

12. On [redacted], the Subject was assigned to care for and supervise Service Recipient B. (Justice Center Exhibit 11 at page 2 of Report #2 - [redacted]) On this date, the Subject was again working with the DA 1[12] and Staff 1[13]. Sometime at around 7:30 p.m. that evening, the Subject was bathing Service Recipient B in the west wing bathroom (Zone 1) where the tub was located behind a door. (Justice Center Exhibit 18 of Report #2 - [redacted]) At some point, while Service Recipient B laid relaxed in a tub of soapy water with his hands on the back of the tub and his head resting on his hands, the Subject exited the bathroom leaving Service Recipient B unsupervised for a period of time. The Subject then went into the kitchen area and sat down at the round table located close to the wall and near the window. (Justice Center Exhibit 18 - round table marked in green) As the Subject sat at the table for a period of time, she was outside of ROS view of Service Recipient B as he laid unsupervised in the tub. There came a time when Staff 1 noticed that Service Recipient B was alone in the bathroom and when she peeked in she saw that he was lying in a full tub of water with his feet crossed. (Justice Center Exhibit 21 - Staff 1's audio interview and transcript at page 3, lines 16 - 24 and page 4, lines 3 - 15 of Report #2 - [redacted]) Staff 1 saw the DA 1 in the kitchen with

[12] [redacted] was the facility's DA 1, a lower level supervisor.
[13] [redacted] was a Direct Support Assistant (DSA) that worked at the facility.

the Subject and waved to her to come to Service Recipient B's location. (Hearing testimony of the Justice Center Investigator and the Subject; Justice Center Exhibits 11 - Daily Assignment Schedules, 13 - Staff 1's signed written statement dated [redacted], 14 - the DA 1's progress note dated [redacted], 16 -17 - the DA 1's and Staff 1's audio interviews with written transcripts and 18 - Floor Plan where round table is marked in green during Subject's hearing testimony of Report #2 - [redacted])

13. The DA 1 headed towards the bathroom and saw that the Subject had left Service Recipient B alone in the bath tub. The DA 1 told Staff 1 to assist Service Recipient B then the DA 1 walked to the dining area where the Subject was seated at the round table. The DA 1 approached the Subject to inform her that Service Recipient B could not be in the bathroom by himself. The Subject stood up, walked away from the DA 1 and continued to walk outside of the facility, while Service Recipient B had remained in the tub. The Subject then got into her car, turned it on and sat there for a period of time. Staff 1 then got Service Recipient B out of the tub, dried him off and put his clothes on. While the Subject had remained outside in her car, she called the police to report that she was being threatened or harassed by her co-workers. After police arrived at the facility, they spoke to the DA 1, Staff 1 and the Subject. The police explained that there was no reason for them to have been called and that the issues involved were human resource ones. The Subject came back into the facility to complete her duties and was able to leave before the end of her usual shift because a night staffer was called to come into work earlier. (Hearing testimony of the Subject and the Justice Center Investigator; Justice Center Exhibits 5 - Case Summary Report, 16 - 17 audio interviews and written transcripts of the DA 1 and Staff 1 of Report #2 - [redacted])

14. Service Recipient B was not injured as a result of the Subject's conduct. (Hearing

testimony of the Justice Center Investigator; Justice Center Exhibits 5, 16 - 17 audio interview and transcripts of the DA 1, refer to Transcript at page 6, lines 10 – 14 of Report #2 - [redacted])

DISCUSSION FOR REPORT #2 – [redacted]
(Service Recipient B - Date of Incident [redacted])

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report under [redacted].

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1 – 18 of Report #2 - [redacted]) The investigation underlying the substantiated report was conducted by Justice Center Investigator, who was the only witness that testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and provided no other evidence.

At the hearing, the Subject's testimony for the most part was consistent with what she told Justice Center Investigator A[14] during the course of the investigation. The Subject stated that she gave Service Recipient B a "shower bath" in the tub where his body was lathered up with soap/body wash as he stood in the tub and then was rinsed off with a shower head. The Subject claimed that she had drained all the water out of the tub before Service Recipient B sat down and laid back to relax with only soapy bubbles left in the tub. She explained that the tub was a DDSO tub with a special latch in the middle that drained the water from the tub before it reached over the ankle level. The Subject testified that during the bath there came a time when Service Recipient

[14] [redacted] was the lead investigator who testified and is referred to as Justice Center Investigator A for [redacted] (Report #2). Refer to footnotes 4 and 10 supra.

B gestured to her with his eyes that he wanted some privacy, so she left him in the tub with only some soapy bubbles in the tub. The Subject stated that she then left Service Recipient B in the bathroom and that she was aware that he had a ROS level of supervision while being bathed. The Subject stated that after she left the bathroom she sat at a round kitchen table near the wall and window and that she was not able to see the Service Recipient from that location. During her testimony, the Subject confirmed the location in the kitchen where she sat at the round table by drawing a green box on Justice Center Exhibit 18. (Hearing testimony of the Subject and Justice Center Exhibit 18)

The Subject further testified that while in the kitchen the DA 1 approached her and became confrontational, at which time she felt threatened and then exited the facility. She got into her car and ultimately called the police to report the situation. When police arrived, she was told that there was no reason for them to have been called and that the situation should be handled by the facility's human resource department. The Subject testified that she had a difficult working relationship with both of her co-workers and that she had talked to a higher-level supervisor (or DA 2) about the problem.

Justice Center Investigator A had interviewed the DA 1 and Staff 1. They both had provided a detailed, compelling and reliable account of what happened. In addition, for the most part, their version of events was consistent. As such, their account of the incident is credited evidence.

The Justice Center contends that the Subject committed neglect when she failed to maintain Service Recipient B's ROS supervision levels as mandated by his treatment plans. The Justice Center argues that the Subject did not maintain the Service Recipient's proper supervision levels when she left him unsupervised in the bathroom in a tub of water.

In order to prove neglect, the Justice Center must establish that the Subject breached a custodian's duty and that resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of Service Recipient B. (SSL §488(1)(h))

The credible evidence establishes that as Service Recipient B's custodian, the Subject had a duty to follow his treatment plans and that she breached her duty to him when she failed to maintain ROS view of Service Recipient B. Instead, the Subject, for a period of time, admittedly left Service Recipient B alone and unsupervised in a bath tub of soapy water. The record supports that the Subject was seated at the round table in a different room, the kitchen, with no visual path into the Zone 1- bathroom where Service Recipient B was located in the tub. The tub was located behind the Zone 1-bathroom door such that the Subject could not have been able to observe Service Recipient B in the tub even if the bathroom door had been opened. Therefore, the Subject could not have maintained Service Recipient B's ROS supervision level because of where she was seated. The Subject even admitted that she was aware of Service Recipient B's ROS supervision level while being bathed and that from her vantage point in the kitchen she could not see him in the bath tub. The Subject also confirmed that while still assigned to maintain Service Recipient B's level of supervision, she left the facility to go outside to sit in her car. In both instances, the Subject failed to maintain proper ROS supervision of Service Recipient B.

Although Service Recipient B was not physically injured as a result of the incident, the Subject's conduct was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of Service Recipient B. Certainly, the soapy water left in Service Recipient B's bath tub created a potential for drowning in water that had been left in the tub as was seen by Staff 1. Additionally, although the Subject denied that there was any water left

in Service Recipient B's bath tub, she claimed that the tub had soapy bubbles in it and that the Service Recipient still had soap on him. Therefore, if Service Recipient B had tried to get out of the tub or moved around on his own while he was not being supervised, he could have slipped and seriously injured himself. Moreover, Service Recipient B had diagnoses of seizure disorder and episodes of SIB (head hitting). If he had a seizure while in the tub or engaged in a head-hitting SIB while not properly supervised, he could have sustained a serious physical injury, especially if it involved the head.

Under these circumstances, it is reasonable to conclude that the Subject's conduct was likely to have resulted in physical injury or serious or protracted impairment of the physical, mental or emotional condition of Service Recipient B. Service Recipient B could have injured his head, had a seizure or, even drowned given the soapy water that was left in the bath tub.

All of the Subject's assertions have been considered but are found to be unpersuasive or lack merit.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged on [redacted] in regard to Service Recipient B. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report.

Category 2 conduct is defined as conduct in which the Subject seriously endangered the health, safety or welfare of Service Recipient B. (SSL § 493(4)(b))

Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report under [redacted] is properly categorized as a Category 2 act.

The Subject's conduct seriously endangered Service Recipient B's health, safety or welfare by leaving him unsupervised in a soapy tub of water. As previously mentioned, Service Recipient B could have had a seizure, sustained a head injury, slipped while moving around in a soapy tub of water or even drown. In addition, Service Recipient B had a history of engaging in SIB episodes that involved him hitting his head so hard that he "breaks" his skin and/or makes it "visibly red." Refer to Justice Center Exhibit 8 of Report #1 - [redacted].

A substantiated Category 2 finding of abuse or neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

DECISION: As to the incident of [redacted] (Report #1), the request of [redacted] that the substantiated report under [redacted], dated [redacted], be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 3 act.

As to the incident of [redacted] (Report #2), the request of [redacted] that the substantiated report under [redacted]

[redacted], dated [redacted], be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 2 act.

This decision is recommended by Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: January 16, 2019
West Seneca, New York