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 #:** [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: October 22, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Kathryn A. Donnelly, Esq.
Kimberly Payne, Esq.
[redacted], Subject

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 #: [redacted]

Before: Elizabeth M. Devane
Administrative Law Judge

Held at: New York State Office Building
333 East Washington Street, Hearing Room A
Syracuse, New York 13202
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: Kimberly Payne, Esq.

[redacted]
By: Kathryn A. Donnelly, Esq.
Levene Gouldin & Thompson, LLP
450 Plaza Drive
Vestal, New York 13850

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 a "substantiated" report dated [redacted], [redacted] of neglect by the Subject of a Service Recipient.

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

Allegation 1

It was alleged that on or about [redacted], while at [redacted], located at [redacted], you committed Neglect against/to a Service Recipient.

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

The investigation revealed the Subject failed to provide proper supervision to the Service Recipient, during which time the Service Recipient was left unattended in the bathtub.

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

4. The facility, the [redacted], located at [redacted], is an IRA that provides residential

services and individualized protective oversight to individuals with behavioral, intellectual and/or developmental disabilities, and is operated by the Office for People With Developmental Disabilities (OPWDD) which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing Testimony of Justice Center Investigator I [redacted] (Investigator)); Justice Center Exhibit 6)

5. At the time of the alleged neglect, the Subject had been employed at the facility since [redacted] 2016 and worked as a Direct Support Assistant (DSA). The Subject's duties included providing direct care for service recipients, including tasks such as feeding, bathing and transporting as well as administration of medication, and supporting their health and safety. The Subject received training in numerous areas including Workplace Safety, Human Sexuality and Promoting Relationships and Implementing Safe Environments. (Hearing Testimony of the Investigator; Hearing testimony of the Subject; Justice Center Exhibits 13, 17, 22 and 25; Subject Exhibit A1) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the 56 year old Service Recipient had resided in a community residence environment for over 20 years and her diagnoses included moderate intellectual disability and schizoaffective disorder. She had a history of maladaptive behaviors including arguing with housemates and resisting encouragement from staff to eat, board her day program bus and proceed with activities of daily living. The Service Recipient enjoyed socializing with staff and going on outings. The Service Recipient could verbally communicate and indicate yes or no to a variety of questions. The Service Recipient used a specialized walker to ambulate, without which she had an abnormal gait as her posture leaned ninety percent to the left. For longer distances, the Service Recipient used a wheelchair to move about. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 8, 9, 10, 21, 22, 23

and 25)

7. The Service Recipient's Individual Plan of Protection directed that when the Service Recipient was in the bathroom at the IRA her supervision level was "Arms length of staff when bathing/showering; only needs assistance for wiping after toileting." (Justice Center Exhibit 9) (Hearing testimony of the Investigator; Hearing testimony of the Subject)

8. The Service Recipient used a specialized tub with a side entrance to facilitate getting into and out of the tub. The handle to open the door was located on the outside of the door. The tub could also be adjusted into a recline position. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 9, 18, 22, 23 and 25)

9. On [redacted], the Subject and two staff, Staff 1 and a Licensed Practical Nurse (LPN), were on duty during the evening shift, [redacted], with eight service recipients at the IRA. After dinner, at 6:30 p.m., as Staff 1 and the LPN cleaned up, the Subject stated to them that she was going to assist the Service Recipient in taking a bath, although that task was not specifically assigned to her or anyone else on the shift assignment sheet. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 15, 16, 17, 21, 22, 23 and 25)

10. While the LPN was in the kitchen she heard the water running. She went to the bathroom to check on the situation because she did not hear anything from the Service Recipient, who was generally talkative or listened to music at bath time. The LPN found the Service Recipient alone in the bathroom, in the tub, reclined, with the water running and the water level up to the Service Recipient's clavicle/shoulder area. The LPN turned off the water and found the Subject in the office, which was eight to ten feet down the hallway, and on the computer. The LPN told the Subject to go into the bathroom and supervise the Service Recipient, then she returned

to the kitchen. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 23 and 25)

11. A few minutes later, at the same time that the Treatment Team Leader (TTL) arrived at the IRA, the LPN went to the bathroom and found the Service Recipient still alone in the tub. The Subject was still in the office on the computer. The LPN finished the Service Recipient's bath and took her out of the tub. The Subject returned to the bathroom and took over caring for the Service Recipient. The Service Recipient was left alone in the bathroom for approximately 10 minutes. The LPN immediately reported the incident to the TTL. (Hearing testimony of the Investigator; Hearing testimony of the Subject Justice Center Exhibits 6, 7, 23 and 25)

12. The Service Recipient received a body check and she exhibited no signs of injury or upset. (Hearing Testimony of Investigator; Justice Center Exhibit 6)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act giving rise to the substantiated report.
- Whether the substantiated allegation constitutes neglect.
- Pursuant to Social Services Law § 493(4), the category of neglect that such act constitutes.

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 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))

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

> "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 neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2, which is defined as follows:

> (b) 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.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act of neglect alleged in the substantiated report that is

the subject of the proceeding and that such act constitutes the category of neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged neglect, the report 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 constitutes the category of neglect as set forth in the substantiated report.

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

DISCUSSION

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

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-18 and 21- 25) The investigation underlying the substantiated report was conducted by the Justice Center Investigator.

The Subject testified in her own behalf and provided one exhibit (Subject Exhibit A1).

In order to prove neglect in this matter, the Justice Center must establish by a preponderance of the evidence that the Subject breached a duty to provide proper supervision to the Service Recipient by leaving the Service Recipient unattended in the bathtub and that her breach was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL §488(1)(h))

The pertinent facts are not in dispute. The credible evidence demonstrates that the Service Recipient required arm's length supervision when she was in the bathroom when bathing/showering. On the date of the incident, the Subject took responsibility for bathing the

Service Recipient. The Subject took the Service Recipient to the bathroom, helped her into the tub, turned on the water, left the bathroom, went into the office which was eight to ten feet down the hall and used the computer there. There is no basis to question the LPN's statement and the Subject's version of events was consistent with the LPN's in all germane aspects. (Hearing testimony of the Investigator; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 9, 21, 22, 23 and 25)

The Subject argued, however, that she was not negligent as she did not breach a duty. The Subject argued that she was put in a position where she had to choose between two competing duties: the Service Recipient's right to privacy and the required supervision level. Additionally, the Service Recipient had masturbated while in the tub on a number of occasions and her plans gave no direction what to do in that instance. (Hearing testimony of the Subject)

The Subject testified that she completed OPWDD Human Sexuality (HS) training. (Subject Exhibit A1) The HS training manual indicated that a service recipient's right of expression has to be balanced with the right to protection. (Subject Exhibit A1, p. 3) On the date of the incident, after the Subject helped the Service Recipient into the tub and turned on the water, the Service Recipient began to masturbate. The Subject testified she then had to balance the Service Recipient's right to privacy with the supervision level. The Subject decided to give the Service Recipient privacy and left the bathroom. The Subject said she could hear the Service Recipient and the water running from her location in the office and that she also heard the water being shut off. (Hearing testimony of the Subject)

The preponderance of the evidence shows that the Subject breached her duty by leaving the Service Recipient unattended. Paramount is the Service Recipient's "Safeguards/Individual Plan of Protective Oversight" that specifically directs arm's length supervision for the Service

Recipient in the bathroom when she is bathing or showering. (Justice Center Exhibit 9) There were no exceptions noted. The HS manual notes the balancing of interests on the basis of "Safety Privacy Responsibility". The first factor the HS manual cites under "Agency and Staff Obligation" is "Providing Safety". (Subject Exhibit A1, p. 14) The HS manual further states "Our job is to keep people "healthy and safe" while still respecting the dignity of their choice ..." (Subject Exhibit A1, p. 15) While the Service Recipient may have masturbated in the tub on occasion, it is not a behavior noted in any of her plans and, even if it were, particularly based on her diagnoses and level of ambulation, it defies rationale that she could be left alone in the tub should that occur. The Subject could have attempted redirection, however, under no instance was it appropriate to leave the Service Recipient unattended. The Subject conceded at the hearing and during two interviews that when she left the Service Recipient unattended she had a lapse in judgment. The Subject breached her duty as she did not maintain arm's length supervision of the Service Recipient while the Service Recipient was bathing.

The Service Recipient was medically examined after the incident and, while no actual injury was found, the credible evidence demonstrates that the Subject's breach resulted in the likelihood of physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. While the Subject was in the office not only was she not within the required arm's length but, based on the IRA floor plan, the Service Recipient was not visible to the Subject and the Subject's attention was on computer email. (Hearing testimony of the Investigator; Justice Center Exhibit 14) The door handle located on the outside of the specialized tub was not reachable by the Service Recipient from the inside of the tub. (Hearing testimony of the Investigator; Justice Center Exhibit 18) When the LPN entered the bathroom the Service Recipient was in the tub, which was in the reclined position, and the water

was up to the Service Recipient's collar bone. The Service Recipient did not have the ability to turn the water off. Further, the Service Recipient, who had limited ambulation, would not have the ability to get out of the tub. (Justice Center Exhibits 7, 21, 22, 23 and 25) While the Service Recipient was not physically injured, evidence in the record established that the Subject's conduct, leaving the Service Recipient unsupervised in the bathtub, was likely to result in physical injury to the Service Recipient, particularly being submerged in the water and even drowning, as well as serious and/or protracted impairment of her physical, mental and/or emotional condition.

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. The substantiated report will not be amended or sealed.

Since 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. The report was substantiated as Category 2 neglect. To prove Category 2 conduct, the Justice Center must establish that the Subject's conduct "seriously endanger[ed] the health, safety or welfare of [the] service recipient ..." (SSL §493(4)(b)) by committing the act.

The Subject argued that category 2 is not applicable as the Service Recipient was not seriously endangered. However, the record reflects that the Subject's conduct, leaving the Service Recipient, who did not have the ability to physically control the water nor the ability to get herself out of the tub if needed, unattended in the reclined tub with water up to her clavicle, created a risk of drowning and/or serious emotional impairment. Consequently, the Subject's actions seriously endangered the health, safety or welfare of the Service Recipient. Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 2 act.

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: The request of [redacted] that the substantiated report 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 Elizabeth M. Devane, Administrative Hearings Unit.

DATED: October 16, 2019
Schenectady, New York

Elizabeth M. Devane
Elizabeth M. Devane
Administrative Law Judge