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 AFTER HEARING

Adjud. Case #: [redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Juliane O'Brien, Esq.

[redacted]

By: Terry M. Sugrue, Esq.
Reden & O'Donnell, LLP
135 Delaware Avenue
Suite 410
Buffalo, New York 14202

[redacted]

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED: The request of [redacted] that the report "substantiated" on [redacted], dated and received on [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated report is properly categorized, or should be categorized as a Category 3.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

[redacted]

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: May 19, 2015
Schenectady, New York

David Molik
Administrative Hearings Unit

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: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Office Building
333 East Washington Street
Syracuse, NY 13202
On: [redacted]

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived.

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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and/or 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 report "substantiated" on [redacted], dated and received on [redacted] of abuse and/or neglect by the Subject of a Service Recipient.

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

Offense 1

> It was alleged that on [redacted], at the [redacted],…while acting as a custodian (DSA), you neglected a service recipient when you failed to timely report a wrap restraint or the observed self-injurious behavior of a service recipient leading to the restraint, conduct a body check, or seek medical attention for the service recipient as a consequence of these occurrences.
>
> This offense has been SUBSTANTIATED as a Category 2 offense pursuant to Social Services Law §493.

3. An Administrative Review was conducted and as a result the substantiated report was retained; but the category was reduced to a Category 3 offense.

4. The facility, [redacted], located at [redacted], is a residential facility and is operated by the New York State Office of

People With Developmental Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject was employed by OPWDD since [redacted] 2007. The Subject worked as a Direct Service Assistant.

6. At the time of the alleged neglect, the Service Recipient had been a resident of the facility for approximately five months. The Service Recipient is a young adult with diagnoses of Mild Intellectual Disability, Fetal Alcohol Syndrome, Borderline Personality Disorder, ADHA, PTSD, and Anxiety. (Justice Center Exhibit 22)

7. On [redacted], the Subject was working the day shift, 7:00 a.m. until 3:00 p.m., and was assigned to the Service Recipient. (Justice Center Exhibit 12)

8. At some point in the afternoon, the Service Recipient became upset and the Subject re-directed him into his room and tried to calm him down. The Service Recipient punched the wall, whereupon the Subject warned him to stop or he would have to be restrained. The Service Recipient then hit his head against the wall, so the Subject performed a wrap, holding the Service Recipient prone on the floor until he calmed down. (Hearing testimony of Subject)

9. The Subject then went into the living room to catch his breath and relax. The Subject then fell ill.[1] After becoming ill the Subject did not recall the specifics of any conversation with staff, but did recall the Service Recipient was in his room, and he (the Subject) did not feel well, so he told staff that was going home. (Hearing testimony of Subject)

10. When the Service Recipient appeared for medication administration at 4:00 p.m., the staff assigned to dispense medication noticed a lump above his right eye. That staff applied

[1] The Subject provided medical evidence that on [redacted], he was diagnosed with pneumonia (Subject Exhibit 1).

ice, started a head injury protocol, and called the triage nurse. (Justice Center Exhibit 7)

11. The Service Recipient was sent to the hospital and discharged later that evening with a diagnosis of Closed Head Injury and Low Back Strain. (Justice Center Exhibit 28)

12. The Service Recipient alleged that the Subject had "slammed [his] head into the floor" so the Justice Center was called and an investigation was initiated. The investigation did not result in a substantiated report for abuse based upon the Service Recipient's claim that the Subject slammed his head; however, the Justice Center substantiated the report for neglect as set forth above (Justice Center Exhibit 5).

13. Facility policy dictates that staff is required to complete an NE-3 form by the end of their shift, any time they use a restraint on a Service Recipient. (Justice Center Exhibit 2 and hearing testimony of the Subject) Staff is also required to fill out a Head Injury Protocol form any time a Service Recipient receives a head injury. (Justice Center Exhibit 29) Staff is required to perform a body check after using a restraint on a service recipient. (Hearing testimony of [redacted]) Finally, staff is required to fill out an NE-1 form upon discovery, any time there is a notable event during their shift. (Justice Center Exhibits 19 and 30)

ISSUES

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

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 evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse and/or neglect; and pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488:

> 1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
>
> (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.
>
> (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct

or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

(c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(h) "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.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) committed the act or acts of abuse and/or neglect alleged in the

substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

(a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

(i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;

(ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(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.

(c) 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.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse and/or 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 abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed a prohibited act, described as "Offense 1" in the substantiated report. The act committed by the Subject constitutes neglect. The category of the affirmed substantiated neglect that such act constitutes is Category 3.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation (Justice Center Exhibits 1-31). The investigation underlying the substantiated report was conducted by [redacted], who testified at the hearing on behalf of the Justice Center. In addition, [redacted], the Administrator for the [redacted], testified for the Justice Center. The Subject testified on his own behalf and provided one document (Subject 1).

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect by failing to report the self-injurious behavior of the Service Recipient. Specifically, the evidence establishes that the Subject had a duty to report both verbally and in writing, that the Service Recipient had banged his head against the wall. The Subject breached that duty by failing to tell any other staff person about the incident. He further breached his duty when he left the premises after his shift was done without first completing a Notable Event Report (NE-1); a Head Injury Protocol (HIP); and a Reactive Intervention Documentation Form (NE-3).

In order to prove neglect, the Justice Center needs to show, "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." (See Social Services Law §488(1)(h)) [redacted], currently the Administrator of [redacted], testified to the policies and procedures adopted by OPWDD which mandate the reporting of incidents involving consumers.

[redacted] stated that a Notable Event (NE-1) form must be completed upon discovery of the event. In this residence, the NE-1 is in the form of a log sheet. The log sheet for the date of the incident does not have any notation for the event; however, it does note the aftermath when the Service Recipient's injury was discovered. (Justice Center Exhibit 20)

In addition, [redacted] stated that a Reactive Intervention Documentation Form (NE-3) must be completed any time a restraint is used. The form itself clearly states that it must be completed by the end of the shift where the restraint was implemented (JC 21). As of the date of the hearing, no NE-3 had been submitted for this incident.

The Subject admitted that he failed to report the incident either to his supervisor or to the staff assigned to this Service Recipient on the next shift. The Subject also admitted that he failed to complete the required forms prior to leaving the facility at the end of his shift. His position is that he was ill, and indeed was diagnosed with pneumonia two days later (Subject Exhibit 1). He testified that he received a call from the facility approximately 30 minutes after he left to go home. He turned around, drove back to the facility and began to fill out the NE-3 form when the shift supervisor advised him that he had been placed on administrative leave and requested he vacate the premises and was unable to complete the paperwork. The record is not clear as to why he was unable to take the forms with him and complete them while he was on administrative leave.

If this had been the only failure by the Subject to adhere to the policies and procedures of the [redacted] and of OPWDD, then that may not have been sufficient to sustain a finding of neglect. However, the subject failed to comply with each and every protocol that he had been trained in and knew were part of his job.

First, the Subject had a duty to report the Service Recipient's self-injurious behavior. Policy dictates that he complete a Head Injury Protocol (HIP) and conduct a body check after the Service Recipient was released from the restraint. By his own testimony, he did not follow either of those protocols. Further, when the next shift came on duty, he should have informed staff of both the behavior and the restraint. Instead, the Subject's only recollection was telling staff that

the Service Recipient was in his room, and that he (the Subject) didn't feel well and was going home. As a result, no one knew what had happened and, when the Service Recipient appeared with a lump on his head, claiming that the Subject had slammed his head into the floor, safety protocols were initiated, and an investigation was commenced.

Clearly, the Subject breached a duty by failing to follow protocols established by the agency. Next, the Justice Center must show that this breach "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." (See SSL §488(1)(h)) The record illustrates that the Service Recipient was injured either when he banged his head against his bedroom wall, or during the wrap that the Subject performed in order to keep him safe. Staff called the triage nurse, started first aid, and initiated the HIP as prescribed by OPWDD policy.

Not only was there an actual injury, but it was foreseeable that by banging his head against the wall, it was likely that the Service Recipient would injure himself. The Subject stated that he restrained the Service Recipient because he was engaging in self-injurious behavior. That alone is sufficient evidence to show that the Subject was aware of the likelihood of injury. This should have triggered the Subject's duty to report the incident; but he failed to do so.

After considering all of the evidence, 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.

The next issue to be addressed is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report**.** This Offense was originally categorized as Category 2 Offense. After review, it was reduced to a Category 3 Offense. Based on all the facts and evidence introduced at the hearing, such a reduction is appropriate in this matter.

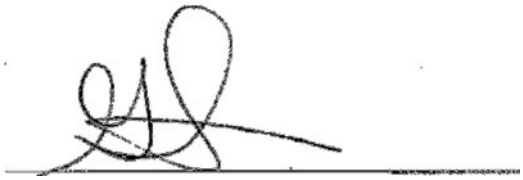
Accordingly, it is determined that the substantiated report is properly categorized as a Category 3.

DECISION: The request of [redacted] that the report "substantiated" on [redacted], dated and received on [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated report is properly categorized, or should be categorized as a Category 3.

This decision is recommended by Gerard Serlin, Administrative Hearings Unit.

DATED: May 4, 2015
Schenectady, New York



Gerard Serlin, ALJ