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]

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

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

[redacted]
By: Jason Jaros, Esq.
Jaros & Jaros
8207 Main Street, Suite 13
Williamsville, NY 14221

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 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 3 act.

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).

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 23, 2017
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: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People With Special Needs
[redacted]
On: [redacted]

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

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

[redacted]
By: Jason Jaros, Esq.
Jaros & Jaros
8207 Main Street, Suite 13
Williamsville, NY 14221

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], 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 2[1]

> It was alleged that on the overnight shift between [redacted] and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision, during which time you did not properly perform a service recipient's bed checks.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Service Law § 493(4)(c).

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

4. The facility, [redacted], located at [redacted], is a residence for developmentally disabled individuals

[1] Allegation 1 of the substantiated report was unsubstantiated.

operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of the Justice Center Investigator)

5. At the time of the alleged neglect, the Subject had work for OPWDD for almost twenty years. The Subject was employed by [redacted] as a Direct Support Assistant (DSA) responsible for the direct care of the service recipients. The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. On the date of the incident, after working his regular work shift (from [redacted]), the Subject left the facility then returned to work the overnight shift from 11:00 p.m. until 7:00 a.m. While working the overnight shift that night, the Subject was assigned as the IRA medication administrator. He was also assigned to handle the supervision and direct care of the four service recipients whose bedrooms were located on the first floor of the IRA. (Hearing testimonies of the Subject and the Justice Center Investigator; Justice Center Exhibits 5 and 19; Justice Center Exhibit 21: an audio CD of the Subject's interrogation)

7. At the time of the alleged neglect, the Service Recipient was a verbal ambulatory fifty year old male, who had been a resident of the facility for more than three years. The Service Recipient shared his first floor bedroom with a roommate. There were two other service recipients who had separate bedrooms on the first floor of the IRA. (Hearing testimony of the Justice Center Investigator and the Subject)

8. The Service Recipient had diagnoses of a moderate intellectual disability, seizure disorder, intermittent explosive disorder and other medical conditions. The Service Recipient wore a helmet during waking hours due to his known history of the sudden onset tonic clonic

seizure activity that occurred with no warning. Although the Service Recipient took a number of different seizure medications (including Depakote), his physician was weaning him from one of those seizure medications (Tegretol) because the Service Recipient's seizure incidents had reduced to one time per year. The Service Recipient's bed had no sensors or alarms to alert staff that he was out of his bed. (Hearing testimonies of the Justice Center Investigator and the Subject; Justice Center Exhibits 5, 12, 19; Justice Center Exhibit 21: an audio CD of the Subject's interrogation)

9. The [redacted] Policy and Procedure Manual (the Policy Manual) required direct care staff to conduct bed checks during sleeping hours. This manual became effective in [redacted]. (Justice Center Exhibit 8). The Policy Manual mandated that staff use a working flashlight or night light to observe individuals with medical concerns (seizures) every thirty minutes. When a service recipient's breathing status could not be confirmed, staff was required to apply a slight touch to the arm, chest or leg in order to confirm that the service recipient was breathing. Bed checks were required to be documented by staff in the facility's communication book. Additionally, the Policy Manual further stated that "[m]ost individuals can be observed from the bedroom door with the assist of a flashlight or from the night light." (Justice Center Exhibit 8)

10. The Subject had not been trained as to how to conduct bed checks under the [redacted] Policy Manual. The Subject conducted his bed checks in the manner that he had always done after his initial training in 2001. (Hearing testimony of the Subject; Justice Center Exhibits 8 and 13)

11. The Service Recipient's Plan of Protective Oversight (POPO), dated [redacted], required 24-hour protective oversight of the Service Recipient and specifically required staff to conduct observations of him every 30 minutes when sleeping, in order to monitor the Service Recipient for signs of seizure activity. The Subject usually conducted his required bed checks of

the Service Recipient by standing in the bedroom doorway to observe the Service Recipient sleeping in his bed, relying on the hallway light for visual observation and listening for breathing sounds coming from him. The Subject usually did not enter the bedroom during bed checks, unless he did not see the Service Recipient or it was necessary to do so for some other reason. (Hearing testimonies of the Justice Center Investigator and the Subject; Justice Center Exhibit 12)

12. At approximately 11:20 p.m. on [redacted], the Subject entered the Service Recipient's bedroom. The Service Recipient and his roommate were sound asleep. The Subject woke the Service Recipient and administered a seizure medication to him. The Subject then left the bedroom. (Hearing testimony of the Subject; Justice Center Exhibits 5, 16 and 21)

13. Thereafter, the Subject conducted bed checks of the Service Recipient every thirty minutes in the same manner that he had always done. The Subject stood at the Service Recipient's bedroom doorway and looked inside the bedroom using the dim light available. The Subject observed what he believed to be the Service Recipient and his roommate in their beds with their blankets over their heads which is how they both usually slept. During the bed checks, the Subject also heard snoring sounds, which he believed were coming from both of the service recipients. The Subject never entered the bedroom during any of his bed checks, nor did he document any of the bed checks in the facility's communication log. The Subject's last bed check training was in 2001. (Hearing testimonies of the Subject and the Justice Center Investigator; Justice Center Exhibits 5, 16 and 19; Justice Center 21: an audio CD of the Subject's interrogation)

14. On [redacted], the Subject's overnight shift was scheduled to end at 7:00 a.m.; however, he was mandated to stay on to work an additional shift in order to meet facility minimum staffing levels. At about 8:00 a.m. on that morning, the staff assigned as the morning medication administrator (Staff-1) tried to locate the Service Recipient. Staff-1 entered the Service

Recipient's bedroom and did not see him lying in his bed. Staff-1 searched for the Service Recipient and could not find him. Staff-1 then returned to the Service Recipient's bedroom and walked further inside the bedroom. Shortly thereafter, the Service Recipient was found deceased, lying face down on the floor in a space between his bed and the nightstand, which was a location that could not be seen when standing in the bedroom doorway. (Hearing testimonies of the Subject and Justice Center Investigator; Justice Center Exhibits 5 and 18; and Justice Center Exhibit 21: audio CD interview of the staff medication administrator)

15. The Service Recipient's death was suspected to be caused from an acute cardiopulmonary arrest, coronary artery disease and related to his seizure disorder history. (Hearing testimonies of the Subject and the Justice Center Investigator; and Justice Center Exhibit 5)

16. Subsequently, the facility's bed check guidelines addressing "Observation/Documentation of Rounds during Sleeping Hours" were amended. Issued in November 2015, the new guidelines established and clarified specific steps that staff must follow to conduct individualized "signs of life procedures." Under the new guidelines, staff are required to enter the room far enough "to see the person clearly and to determine if he/she is breathing normally, without distress…[including] visually observing his/her face unless the person routinely covers his/her face with a blanket while sleeping." If a person's face is not visible on a regular basis then staff are required to notify the supervisor so that the treatment team could convene to determine what the appropriate signs of life procedures need to be followed for that particular person. The revised guidelines also provided that staff could use a "flashlight" or "small night light" to monitor the sleeping person or even the "hall lighting" if it was bright enough to see the person. (Justice Center Exhibit 8 and Subject's Exhibit A)

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 neglect.
- Pursuant to Social Services Law § 493(4), the category of 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 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:

> "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 3, which is defined under SSL § 493(4)(c) as follows:

> 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 substantiated report that is the subject of the proceeding and that such act or acts constitute 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 proves 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, 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 1-20) The Justice Center also presented audio recordings of the Justice Center Investigator's interview of witnesses and interrogation of the Subject. (Justice Center Exhibit 21) The investigation underlying the substantiated report was conducted by the Justice Center Investigator, who testified at the hearing on behalf of the Justice Center.

The Subject testified in his own behalf and presented one document that was admitted into evidence. (Hearing testimony of the Subject and Subject Exhibit A)

At the hearing, the Subject's testimony, for the most part, was consistent with his interrogation that was conducted on [redacted]. At the time of his interrogation, the Subject told the investigator that he was familiar with the facility's bed check policy. (Justice Center Exhibit 21: an audio recording of the Subject's (2-Part) Interrogation)

The Subject testified that, while working the night shift on the date in question, he conducted periodic bed checks of the Service Recipient every thirty minutes, but did not appropriately document the checks. The Subject also testified that he conducted the bed checks while he stood in the doorway to the bedroom and that he could see inside the bedroom from the dim dining room light that was always on. The Subject testified that he saw blankets "lumped up" or gathered on top of the Service Recipient's bed and that he heard snoring, which he assumed to be coming from both the Service Recipient and his roommate. The Subject testified that he is familiar with the Service Recipient's POPO and was aware of his history of seizures.

The Subject also testified that during those bed checks he did not enter the bedroom, did not use a flashlight, did not turn on the lights, nor ensured that the Service Recipient was breathing by actually touching or seeing the Service Recipient underneath his blankets. The Subject also testified that he had been initially trained to do bed checks in 2001, but since that time has had no further training on the issue.

The Subject argues that the facility's bed check guidelines applicable at the time were vague and that the Subject could not have seen the Service Recipient lying on the floor given where he was located. In addition, the Subject pointed out that when Staff-1 (the morning medication administrator) entered the Service Recipient's bedroom Staff-1 initially could not see the Service

Recipient lying on the floor. The Subject further argues that, under the circumstances, the Subject's actions were reasonable, such that the facility adopted and incorporated some of the steps undertaken by the Subject into the facility's revised guidelines. (Subject's Exhibit A)

The Justice Center argues that the Subject could not have conducted the required bed checks because he did not document them and that, considering the cold state of the body at the time it was found, the Service Recipient had been lying on the floor for over four hours.

The facts relevant to the issues in this hearing are mostly undisputed. In weighing the evidence, the Subject's hearing testimony is found to be credible and, as noted above, consistent with what he said during his interrogation. (Hearing testimony of the Subject, Justice Center Exhibits 16 and 19; Justice Center Exhibit 21: an audio CD of the Subject's interrogation.)

In order to prove neglect, the Justice Center must establish that the Subject breached a custodian's duty and that the breach resulted in or 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 Justice Center proved by a preponderance of the evidence that the Subject breached his duty to provide proper supervision and conduct proper bed checks of the Service Recipient under these factual circumstances.

Although the Subject may not have been formally re-trained to conduct bed checks under the 2002 Policy Manual, he was aware of and familiar with the Service Recipient's POPO, which required staff to conduct "30 minute periodic observations" of the Service Recipient in order to monitor "signs of any seizure activity." (Justice Center Exhibits 8 and 12-13) Therefore, the Subject had a duty to follow the Service Recipient's POPO and observe the Service Recipient during bed checks even if the Service Recipient had a habit of sleeping with his blankets over his

head or entire body.

Here, the Service Recipient was usually hidden beneath his blankets during bed checks. Therefore, a glance in the bedroom from the doorway did not suffice as proper supervision or proper performance of bed checks of the Service Recipient. In this case, to properly supervise and conduct bed checks in compliance with the mandates under the Service Recipient's POPO, it was reasonable to have expected the Subject to walk into the bedroom and to physically see the Service Recipient's head as he laid in the bed or to even uncover his blankets enough so as not to awake him, but to observe that he is safely lying in the bed with no signs (visible or otherwise) of seizure activity. However, the Subject admittedly has failed to do so.

Consequently, the Subject has breached his duty to the Service Recipient. The Subject did not properly supervise the Service Recipient because he was unaware that the Service Recipient had fallen out of his bed. Additionally, the Subject did not properly conduct bed checks because he failed to observe the Service Recipient lying in his bed and ensure that there were no signs of seizure activity. The Subject also failed to properly document the bed checks that he had conducted.

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.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse or 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 is properly categorized as a Category 3 act.

Substantiated Category 3 findings of 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.

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 3 act.

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

DATED: May 11, 2017
West Seneca, New York