

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

In the Matter of the Appeal of

████████████████████

Pursuant to § 494 of the Social Services Law

**FINAL
DETERMINATION
AFTER
HEARING**

ADJUDICATION CASE

████████████████████

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.

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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 ██████████ that the substantiated report ██████████ ██████████ be amended and sealed is denied.

The Subject has been shown by a preponderance of the evidence to have committed abuse.

The substantiated report properly determined that the Subject's abuse of the service recipient constituted Category 1 conduct.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Person's Central Register, and shall result in permanent placement of the Subject on the vulnerable persons' central registry pursuant to SSL § 493(5)(a) and SSL § 495.

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: Schenectady, New York
December 12, 2014



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**

ADJUDICATION CASE

[REDACTED]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: Adam Clayton Powell Jr. State Office Building
163 W 125th St
New York, NY 10027
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.

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

[REDACTED]

JURISDICTION

The New York State Vulnerable Persons' Central Register (hereinafter "the VPCR") maintains a report substantiating [REDACTED] (hereinafter "the Subject") for abuse and 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.

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 [REDACTED] of physical abuse by the Subject against service recipient [REDACTED] resulting in injury to the service recipient.
2. The initial report alleges, in pertinent part, that on or about [REDACTED] [REDACTED] committed an act of abuse and neglect at [REDACTED] [REDACTED], (hereinafter "the Hospital") when he inappropriately made contact with his hand against [REDACTED] mouth resulting in injury to his mouth. (Justice Center Exhibit 4)
3. The initial report was made to the Justice Center for the Protection of People with Special Needs (hereinafter "the Justice Center") on [REDACTED] and was investigated by the [REDACTED].
4. On or about [REDACTED], the Justice Center substantiated the report against the Subject for *abuse and neglect*. The Justice Center concluded that:

Offense 1

On [REDACTED], at the [REDACTED], located at [REDACTED] [REDACTED], while acting as custodian (RN), you committed physical abuse when you shoved a service recipient and caused bleeding of the lips. This

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action intentionally or recklessly caused injury or the likelihood of serious or protracted impairment of the physical, mental or emotion condition of a service recipient.

This offense has been SUBSTANTIATED as Category 1 physical abuse pursuant to Social Services Law § 493.

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

6. At the time of the alleged abuse the Subject was employed as a Registered Nurse by the Hospital located at ██████████. The Hospital is a *facility or provider agency* that is subject to the jurisdiction of the Justice Center. At the time of the alleged abuse the service recipient, ██████████, was a patient at the Hospital in unit ██████████, a psychiatric/behavioral unit, the unit of which the Subject was the RN on duty at the time of the incident. (Justice Center Exhibit 4)

7. ██████████ who had been residing in a nursing home, was admitted to unit ██████████ of the hospital on ██████████, approximately three days prior to the date of the incident at issue, with multiple serious physical and psychiatric health issues. He had significant weakness in his left side, required a walker to be ambulatory and could not get out of bed safely without assistance. (Justice Center Exhibit 17)

8. On the night of ██████████, Certified Nursing Assistant, ██████████ ██████████ was assigned from her home floor on unit ██████████ to unit ██████████ to provide service recipient ██████████ with constant observation for safety reasons to prevent him from falling. (Testimony of ██████████)

9. Upon her arrival in his room at approximately 11:00 pm, ██████████ was asleep, lying prone in his bed, and ██████████ sat on a chair to his side near the foot of his bed. Shortly thereafter, ██████████ awoke and spoke to ██████████. He appeared to ██████████ to be calm and

██████████

he expressed his appreciation for her presence repeatedly. He also said things that made ██████████
██████████ uncomfortable including telling her that he loved her. (Testimony of ██████████)

10. Shortly thereafter ██████████, who had been doing his rounds as one of the two Registered Nurses on unit ██████████ for the night shift, called ██████████ to the doorway of the room to provide her with a report and to find out from her if there were any concerns. (Testimony of ██████████)

11. ██████████ indicated her mild concern with ██████████ communications but also indicated that she was not comfortable following ██████████ instructions to her, to tell ██████████ to stop talking to her. Subsequently, ██████████ continued on his rounds, leaving ██████████ to return to ██████████ bedside wherein she continued to speak with him. (Testimony of ██████████)

12. Shortly thereafter, ██████████ returned to ██████████ room and admonished ██████████. to stop talking. ██████████ was not receptive to ██████████ and responded by “spewing obscenities.” ██████████ then told ██████████ that he would either have to be put in a “quiet room” or be given a needle. ██████████ was not deterred from talking by this threat and continued to curse at ██████████. ██████████ quickly approached ██████████ and grabbed both of his wrists, pinning ██████████ to the bed while continuing to threaten him. (Testimony of ██████████)

13. ██████████ then left the room briefly and returned with a syringe in his hand. He approached ██████████ and with the other hand, he made contact with ██████████ mouth forcefully with his palm face down causing ██████████ head to be pushed back against his pillow. (Testimony of ██████████)

14. When ██████████ removed his hand, ██████████ was subdued and with the

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help of two male CNAs, namely, ██████ and ██████, ██████ administered the IM medication contained in the syringe. During this interaction ██████ began scolding ██████ for attempting to spit at him. (Testimony of ██████)

15. After ██████ and the CNAs left the room, ██████ was crying and very upset. ██████ observed blood on his mouth. ██████ put a wet paper towel on ██████ mouth and from the doorway of his room, she told another CNA, ██████ that ██████ mouth was bleeding and requested a washcloth. (Justice Center Exhibit 17)

16. ██████ advised ██████ that ██████ was bleeding and he returned to the room with a washcloth to clean ██████ mouth. ██████ wiped ██████ mouth, during which, ██████ complained that ██████ was hurting him and ██████ resumed scolding ██████ for trying to spit at him. (Testimony of ██████)

17. Sometime after ██████ left the room, ██████ went to sleep and when he awoke several hours later at approximately 6:00 am, his lip was visibly swollen. ██████ immediately went to Hospital administration and personally reported the incident. Thereafter, that morning, she made a handwritten record of the event. (Justice Center Exhibit 7)

18. ██████ also reported the injury by way of the hospital's Occurrence Reporting Form, prepared at 6:00 am that day, wherein he indicated that the patient was injured, his lip was swollen and that it was due to the RN attempting to "deflect him from spitting at staff." (Justice Center Exhibit 18)

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 or neglect.

- Pursuant to Social Services Law § 493(4), the category level of abuse that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse 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 or neglect presently under review was substantiated. A “substantiated report” means a report made “... if an investigation determines that a preponderance of evidence of the alleged neglect and/or abuse exists.”

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 or neglect; and pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

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

Substantiated reports of abuse 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, 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 cited in the substantiated report constitutes the category level of abuse set forth in the substantiated report. The Justice Center will inform any inquiring licensing or provider agency that the Subject is substantiated in the report. If applicable, its existence is subject to disclosure to licensing and provider agencies making inquiry concerning the Subject pursuant to SSL §§ 495(2) and 424-a.

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If the Justice Center did not prove the abuse by a preponderance of evidence, the substantiated report must be amended and sealed. Its existence will not be disclosed to licensing and provider agencies.

DISCUSSION

The Justice Center has succeeded in establishing by a preponderance of evidence that the Subject, ██████████, did commit the abuse as alleged in the substantiated report. The substantiated report is properly categorized as Category 1 conduct.

In support of its indicated findings, the Justice Center presented a number of documents obtained during investigation. (Justice Center Exhibits 1-18) The investigation underlying the substantiated report was conducted by three people, namely ██████████ ██████████. Testifying for the Justice Center at the hearing were CNA, ██████████, RN ██████████, and VP of HR, ██████████. Signed statements were obtained from the Subject, RN, ██████████ ██████████, CNA, ██████████, CNA, ██████████, and RN ██████████.

██████████ testified on his own behalf and introduced nine exhibits into evidence. (Subject Exhibits 1-9)

The Justice Center primarily relied on the testimony of ██████████ together with the well documented fact of a swollen lip sustained by the service recipient, ██████████.

██████████ provided detailed hearing testimony that she had an unobstructed view of ██████████ ██████████ causing, by physical contact, physical injury to ██████████ She stated that she saw ██████████ ██████████ use unnecessary and excessive physical force on ██████████ by firstly, grabbing his

■■■■■■■■■■
 wrists¹, by secondly, hitting his mouth² and by thirdly, wiping his mouth forcefully with a washcloth thereafter.³ Her testimony was that both she and ■■■■■■■■■■ were extremely distressed as a result of ■■■■■■■■■■ actions.

■■■■■■■■■■ testimony further recounted that at approximately 6:00 am, when ■■■■■■■■■■ awoke, and his swollen lip was undeniably apparent, ■■■■■■■■■■ commented to another staff member in her presence that ■■■■■■■■■■ “must have bitten his lip.”

There were six statements from medical staff who directly observed that ■■■■■■■■■■ had a swollen lip on ■■■■■■■■■■ and this fact was not disputed by ■■■■■■■■■■. (Justice Center Exhibit 7 and Justice Center Exhibits 14-18)

■■■■■■■■■■ position was that he acted in self-defense in attempting to deflect ■■■■■■■■■■ from punching and spitting at him, that some other medical issue might have caused or exacerbated the swelling and that the Hospital had failed to provide staff with a clear policy to address the problem of spitting patients.

■■■■■■■■■■ testimony was consistent with his signed statement which outlines his version of events as follows:

“Patient was talking inappropriately to 1:1 NA and was instructed by RN that it was time to sleep and not to talk. Patient became vulgar and abusive and refused verbal direction to calm down. RN approached patient to administer Haldol IM, and patient attempted to punch RN. When RN restrained his arm, patient attempted to spit at RN. RN attempted to deflect spitting action. IM was administered. In the AM, patient’s upper lip was observed to be swollen. Ice

¹ There is discrepancy in the record regarding this contact. ■■■■■■■■■■ testified that he held down only ■■■■■■■■■■ right hand in self-defense when ■■■■■■■■■■ attempted to strike him, which he said occurred after he returned to the room with a syringe to medicate ■■■■■■■■■■

² There is discrepancy in the record regarding this contact. ■■■■■■■■■■ testified that ■■■■■■■■■■ was clearly about to spit at him, that he only covered and moved ■■■■■■■■■■ mouth away and that there was no injury to ■■■■■■■■■■ evident until the following morning when swelling to the lip appeared.

³ There is discrepancy in the record regarding this contact. ■■■■■■■■■■ testified ■■■■■■■■■■ forcefully wiped ■■■■■■■■■■ bloody lip causing him further pain. ■■■■■■■■■■ testified that he saw no blood and only cleaned away saliva that had gathered on his mouth.

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pack applied to site.” (Justice Center Exhibit 9)

In hearing testimony, ██████████ explained that he only held down ██████████ right arm to avoid getting punched by him.

██████████ further explained that he became aware of ██████████ intention to spit at him because ██████████ had just attempted to punch him and was immediately thereafter making noises that indicated that he was “gathering spit in his mouth.”

██████████ testified that he used his hand only to redirect ██████████s mouth away from him to deflect the spit, that he immediately thereafter administered the IM medication, with the assistance of the CNAs who were present, and that he then left the room.

██████████ admitted that CNA ██████████ had told him at approximately 12:30 am that ██████████ had asked her for a washcloth as ██████████ was bleeding. He stated that when he went back into the room, he washed only spit and saliva from ██████████ lips and that he did not see any blood or other evidence of injury upon his examination of the area. (Testimony of ██████████; Appellant)

A handwritten signed statement of CNA ██████████ was admitted into evidence. It indicates that ██████████ and ██████████ were both yelling. ██████████ statement was that she heard ██████████ twice say “I’m not scared of you and I’ll punch you in the face.” and that she further heard ██████████ threaten to spit in ██████████ face. (Justice Center Exhibit 4)

While ██████████ may have heard words spoken from somewhere outside of the room, the evidence did not put her in ██████████ room that night and she was not a witness to what happened there at the critical time. Furthermore, although this evidence may provide some context for what occurred, it certainly does not provide a justification for the alleged act(s) of

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abuse.

██████████ testified that ██████████ may have had some preexisting medical condition that caused a “propensity for swollen lips.” He speculated that ██████████ may have been dehydrated which might have caused his lip to swell and bleed. He indicated that he had unsuccessfully attempted to obtain copies of ██████████ medical records to see if that theory could be supported. Although this premise may be conceivably possible, it is much more probable that the swollen lip was caused by ██████████ use of force as was described by ██████████

██████████ further testified that he had unsuccessfully searched extensively for a hospital policy that dealt specifically with how staff should address the issue of patient spitting. Although he had received other trainings and reviewed other policies, such as ██████████ ██████████ Hospital-Wide Policy and Procedure ██████████ against abuse, neglect and mistreatment of patients (Justice Center Exhibit 12), there was nothing to guide staff in dealing with this particular problem. Nonetheless, this reasoning does not provide a valid justification for ██████████ to have deviated from the general, but very clear Hospital-Wide Policy and Procedure ██████████ that prohibits inflicting injury on patients.

Lastly ██████████ raised the concern that the Investigative Report (Justice Center Exhibit 4) refers to interviews with individuals without providing any statement or information about what they had to say, if anything, about what happened between ██████████ and ██████████ on ██████████. ██████████ indicated that evidence from some of the people named in the report might have exonerated him.

The Administrative Law Judge presiding over the hearing is satisfied that the Justice Center provided as evidence all statements that it did obtain regarding this matter. ██████████

██████████ had ample opportunity to call anyone that he thought would be helpful to his case as a witness or to provide any other relevant evidence at his hearing.

Insofar as ██████████ testimony conflicts with ██████████ version of events, his hearing testimony is not credited evidence on any of the points of dispute. ██████████ testimony was clear and forthright. She was a disinterested witness who had no reason to fabricate her version of events and her upset over the incident was apparent and genuine, while the Subject had every reason to fabricate his testimony, the preservation of his employment.

In the final analysis, the evidence shows that the acts committed by ██████████ did constitute abuse under SSL§488(1)(a) as it was "...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."

██████████ exercised excessive and unnecessary force against ██████████ causing his lip to become swollen and to bleed. The language of SSL§488(1)(a) is very specific and clearly contemplates the type of situation as has arisen in this case.

The Justice Center has met its burden of proving by a preponderance of the evidence that ██████████ committed the abuse alleged in the substantiated report. The substantiated report will not be amended or sealed.

The substantiation of the report having been determined, the next question to be decided is whether the substantiated allegation constitutes the category level of abuse as set forth in the report. Pursuant to Social Services Law § 493(4), the substantiated allegation does fit within the meaning of a Category 1 serious physical abuse, to wit: intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law. Although the

██████████
service recipient's injury may not constitute the most severe example of injury imaginable, he was hurt, bleeding and suffered from a swollen lip nonetheless.

A substantiated Category 1 finding of abuse or neglect will result in the Subject being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 1 report will be disclosed to entities authorized to make inquiry to the VPCR.

DECISION:

The request of ██████████ that the substantiated report ██████████
██████████ be amended and sealed is denied.
The Subject has been shown by a preponderance of the evidence to have committed abuse.

The substantiated report properly determined that the Subject's abuse of the service recipient constituted Category 1 conduct.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Bureau.

DATED: November 4, 2014
Spring Valley, New York


Sharon Golish Blum, Esq.
Administrative Law Judge