

**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: Tracy Steeves, Esq.

████████████████████
████████████████████
████████████████████

By: Constance Brown, Esq.
CSEA, Inc.
143 Washington Ave.
Capital Station Box 7125
Albany, New York 12224

██████████

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 dated ██████████, ██████████, received and dated ██████████, be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed abuse and/or neglect.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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
April 14, 2015



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

████████████████████

Pursuant to § 494 of the Social Services Law

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjud. Case #:

██████████

Before: Diane Herrmann
Administrative Law Judge

Held at: NYS Justice Center
Administrative Hearings Unit
401 State Street
Schenectady, New York 12305
On: ██████████

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

████████████████████
████████████████████
████████████████████
By: Constance Brown, Esq.
CSEA, Inc.
143 Washington Ave.
Capital Station Box 7125
Albany, New York 12224

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 Justice Center, Administrative Appeals Unit (AAU) amend the report to reflect that the Subject is not a subject of the substantiated report. The AAU 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], received and dated [REDACTED], of neglect by [REDACTED] (Subject) against a Service Recipient. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).

2. The initial report alleges, in pertinent part, that:

Offense

It was alleged that on or about [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian, you neglected a (S)ervice (R)ecipient when you failed to provide required supervision, resulting in an injury or a risk of injury to him.

This offense has been SUBSTANTIATED as Category 3 neglect pursuant to Social Service Law § 493.

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

4. At the time of the alleged abuse, the Subject was employed as a Direct Care Aide

██████████
at ██████████, a facility run by OPWDD, which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. On ██████████ the subject was working the 2:30pm-10:30pm shift and was assigned to House ████ as a one/one aide to the Service Recipient.

6. The Service Recipient had an enhanced supervision protocol plan that required a one/one staff member with a sweeper.

7. During the day and evening shift the Service Recipient's one/one aide was required to be within arm's length of the Service Recipient. During the overnight shift the enhanced supervision required the Service Recipient to be checked every 15 minutes.

8. The sweeper was required to enter the Service Recipient's bedroom and bathroom prior to him entering and remove all items smaller than a baseball.

9. On the morning of ██████████ the Service Recipient told staff that he had placed a piece of metal, half a plastic cap from a shampoo bottle and a rubber spout from a soap dispenser in his rectum during the night.

10. The Service Recipient was brought to the medical unit and a physician removed what was described as a rubber spout from a soap dispenser from the Service Recipient's rectum. No injury was reported.

11. The Service Recipient admitted to the treating physician that he had not put the other items in his rectum.

12. On ██████████ the Service Recipient gave a statement and said that the Subject took him to the bathroom and he took off the tube from a broken soap dispenser. The Service Recipient stated that he hid the item in his clothes and the Subject bagged up the broken soap dispenser and threw it out.

██████████

13. ██████████, the Service Recipient gave another statement and said the Subject took him to the restroom on the evening of ██████████, and he took off the tube and inserted it in his rectum in the bathroom. He said the Subject was in the doorway but she was not watching him.

14. ██████████, the Service Recipient gave another statement and said that his previous statements were false; he stuck the tube in his rectum at night, then changed his mind and said he did it in the bathroom. The Service Recipient said the door was propped open with a basket and then stated it was propped open with a trash can. The Service Recipient said that the Subject was not watching him.

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 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/or 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 not established by a preponderance of evidence that the Subject neglected the Service Recipient and that neglect led to injury.

The Justice Center presented one witness and admitted into evidence the investigatory statement forms completed by the four staff members on the 2:30pm-10:30pm shift, a recording of the Subjects interrogation, a video of the exterior of the house that shows people outside the house on smoke breaks and other investigatory documents. The Subject testified on her own behalf, called one witness and entered into evidence the █ Policy on enhanced supervision and the statements made by four residents of House █.

The witness for the Justice Center was the case investigator, █. █ summarized his investigation and introduced the recording of the Subject's interrogation. The investigator testified that he reviewed the key card log of the Subject and he

██████████ documented when she left the house for smoke breaks. The Justice Center admitted into evidence a portion of the log with his handwritten entries. The Justice Center also admitted into evidence a Staff Accountability and Relief Tracking System for the day in question. Based on the Staff Accountability sheet the Subject was signed on to watch the Service Recipient from 4:17pm-8:00pm but her key card indicated that she went outside between 5:22-5:29pm.

The Subject testified in her own defense. The Subject stated that she never left the Service Recipient alone. The Subject said that perhaps she failed to fill out the staff accountability sheet correctly. The Subject was able to describe the enhanced supervision plan and clearly stated that she never left the Service Recipient alone.

The Subject also called ██████████, who worked the 2:30-10:30 pm shift on the day in question. ██████████ testified that the Service Recipient was not left alone during the shift. ██████████ testified that when staff took smoke breaks during dinner they did not use the staff accountability sheet to sign in and out because everyone was around the dinner table. This evidence adds credibility to the Subject's statement.

On cross examination, the investigator testified that he did not review the Service Recipient's actions or activities during the day or the overnight shift. The investigator stated that because the Service Recipient was specific about when the incident happened and who his one/one aide was he investigated only the Subjects actions during the 2:30pm-10:30pm shift.

According to the Service Recipient's plan a male staff member should have brought the Service Recipient to the bathroom and a sweeper should have checked the bathroom before he entered. The protocol is clear that the one/one aide cannot be a sweeper. If there was a broken soap dispenser in the house bathroom the sweeper should have found it before the Service Recipient went in and the Service Recipient should have been in the bathroom with a male staff

██████████
member.

In order to prove by a preponderance of the evidence the charges against the Subject the Justice Center needs to show both the Subject neglected the Service Recipient and the neglect lead to injury. The Justice Center cannot rely on half of the Service Recipient's statement when the other half contradicts the theory of the case. The Justice Center said they didn't need to investigate any other time periods or employee shifts because the Service Recipient told them when it happened. But the Service Recipient also said the Subject was with him. The Justice Center cannot argue the event happened at a specific time because the Service Recipient said so and argue the Subject was outside the house when it happened because the Service Recipient said the Subject was with him.

The staff members all stated that they did not see the Subject alone on the day in question. The time period the Subject is alleged to have left the house without having another staff sign on the staff accountability sheet was dinner time. ██████████ testified that when the staff took smoke breaks during dinner the practice was not to use the sign in/off sheet. ██████████ had no reason to lie. Based on his testimony it was ok if the Subject left to smoke at dinner because the staff was all in the dining room and within arm's length of the Service Recipient. A review of the exhibits submitted show the Service Recipient using the bathroom only one time, approximately 3:43pm-4:17 pm when ██████████ signed on and the Subject swept the bathroom. All the staff members state that the Service Recipient used the bathroom during the day but there does not appear to be any document to show which male staff member took him to the bathroom and who swept the bathroom.

The Justice Center states that the Subject was less than truthful in her interrogation. The Subject testified at the hearing. The Subject's demeanor did not appear less than truthful but

[REDACTED]
 merely unclear on the details of the day because at the time it seemed like any other work day. Testimony was provided that gave a plausible explanation for why the Subject did not have a fellow staff member sign on the staff accountability sheet for the seven minutes she left the house. The only statements that place the Subject with the Service Recipient when the incident happened are from the Service Recipient. The Subject's direct testimony is found more credible than the Service Recipient's inconsistent and contradictory statements. It is well established that hearsay evidence cannot prevail against a witness's sworn and not inherently incredible testimony. *Matter of Perry* 37 AD2d 367 (3rd Dept. 1971). E.g., *In the Matter of the Claim of Lucy Lopez v. the Commissioner of Labor*. Slip Opinion 514794 (3rd Dept. January 17, 2013).

The Justice Center has failed to prove by a preponderance of the evidence that the Subject committed neglect. The substantiated report will be sealed.

DECISION

The request of [REDACTED] that the substantiated report dated [REDACTED], [REDACTED], received and dated [REDACTED], be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed abuse and/or neglect.

This decision is recommended by Diane Herrmann, Administrative Hearings Unit.

DATED: August 14, 2014
Schenectady, New York

A handwritten signature in cursive script, appearing to read "Diane Herrmann", written over a horizontal line.

Diane Herrmann, ALJ