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: Jennifer DeStefano, Esq.

[redacted]
By: Thomas Latin, Esq.
Sheehan, Greene, Golderman & Jacques, LL
54 State Street, Suite 1001
Albany, New York 12207

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 , dated and received on 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: Schenectady, New York
July 6, 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

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: Office of Children and Family Services
Spring Valley Regional Office
11 Perlman Drive
Spring Valley, New York 10977
On: [redacted]

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [1] (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 , dated and received on 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 , at , located at , while acting as a custodian, you committed neglect when you failed to call the nurse when a service recipient recovering from an operation and prescribed a narcotic for pain requested pain medication.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493.

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

[1] The Subject was identified as in the substantiated report, however, during a Prehearing Conference, the Subject advised the presiding administrative law judge that his correct legal name is and requested that he be referred to as such.

was retained.

4. The facility, , located at , is a secure facility that provides psychiatric treatment to adults and is operated by the New York State Office of Mental Health (OMH), 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 had been employed at the facility for three years as a Security Hospital Treatment Assistant (SHTA). (Hearing testimony of ; Subject)

6. At the time of the alleged neglect, the Subject was working a second shift in the facility infirmary, from at 11:00 p.m. until at 7:00 a.m., after having worked the preceding day shift elsewhere in the facility. (Hearing testimony of ; Subject)

7. At the time of the alleged neglect, the Service Recipient was a patient in the facility infirmary, where he was recovering from colon resection surgery, due to colon cancer, which had been performed eight days prior thereto. He had been prescribed pain medication on an as needed basis, with a dosage of one pill for mild or moderate pain and two pills for more intense pain. (Hearing testimony of Director)

8. The protocol for a patient to receive pain medication is for the patient to ask a SHTA, who is responsible to convey the request to the nurse on duty. The last time that the Service Recipient had requested and was provided with pain medication, prior to the time of the alleged neglect, was at 3:30 p.m. on , when he requested and received two pills for his pain. (Hearing testimony of Director)

9. Subsequent to the commencement of her shift at 11:00 p.m. on ,

Registered Nurse (RN) went into the Service Recipient's infirmary bedroom, where she checked his incision, spoke to him briefly, and left him to sleep. After that, RN did not speak to or enter the Service Recipient's infirmary bedroom for the duration of the shift, although she looked through the window of his infirmary bedroom door periodically while performing her rounds on the unit. (Hearing testimony of RN)

10. During the shift, the Service Recipient made three requests for pain medication to the Subject, each of which was acknowledged by the Subject. The Service Recipient approached the Subject in the infirmary hallway at 1:00 a.m., 2:00 a.m. and 6:00 a.m. At 6:00 a.m., the Service Recipient confronted the Subject loudly and angrily because his pain medication had not been provided. Thereafter, the Service Recipient's bedroom door was slammed shut. (Justice Center Exhibit 7)

11. At no time throughout the shift was RN advised of the Service Recipient's requests for pain medication, nor did he receive any pain medication until after the shift changed, when he was given two pills at 7:15 a.m. on . (Justice Center Exhibit 7)

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/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 the 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 the evidence that the Subject committed a prohibited act, described as Offense 1 in the substantiated report. Specifically, the evidence establishes that the Subject committed an act of neglect by failing to notify a nurse that the Service Recipient, who was recovering from surgery and was prescribed a narcotic for pain,

requested pain medication.

Under SSL § 488(1)(h), neglect was established in that the Subject's conduct was an, "inaction or lack of attention," that breached his duty and that resulted in a, "serious or protracted impairment of the physical, mental or emotional condition," of the Service Recipient.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-20) The investigation underlying the substantiated report was conducted by Director of Risk Management, who, together with SHTA and RN , were the three witnesses who testified at the hearing on behalf of the Justice Center.

The Subject testified on his own behalf and provided one document as evidence. (Subject Exhibit 1)

The Subject's answer to the allegations was his denial that he had any contact whatsoever with the Service Recipient at any time during the shift.

The Service Recipient was interviewed by Director on . The Service Recipient's statement was that:

> I woke up at 1:00 a.m., went to the bathroom. I went to SHTA and asked him for my pain medication. SHTA said he would call the nurse. I went back to bed. No nurse arrived. At 2:00 a.m. I went to the door, SHTA had gone back to sleep. I asked him again for pain medication. I stayed awake, the nurse did not come. At 6:00 a.m. I saw SHTA bringing a patient past my room to get a shower. I asked him again for my pain medication, he said something like, you didn't get medication? and I said, thanks to you I didn't. SHTA then slammed the door of my bedroom in my face. He didn't say anything else. At 7:00 a.m. I saw RN , I told her that I didn't get pain medication and I needed it. She brought the pain medication right away. (Justice Center Exhibit 8)

RN was interviewed by Director and she stated that:

> she gave the [Service Recipient] pain medication at 0715 hour. She said that during her rounds first thing in the morning the [Service Recipient] requested pain medication and stated that he had asked for medication during the night and had not received any. RN said that the medication administration record and the progress notes indicated that the [Service Recipient] did not receive any medication during the night shift. (Justice Center Exhibit 7)

Nursing Assistant 1 (NA1) filled out Part 16 of the facility Incident Reporting Form generated on , entitled: Initial Investigation Findings. She wrote that:

> Pt said on the night of SHTA was on duty He ask (sic) him to call the Nurse that he was having alot (sic) of pain. He asked him at 1am, 2am at 6am he asked him again. and (sic) he walked past his room and slammed the door in his face. (Justice Center Exhibit 4)

Senior Security Hospital Treatment Assistant (SRSHTA) completed other parts of the Incident Reporting Form, including Part 15, entitled: Narrative Description. She stated that the Service Recipient reported to her that he approached the Subject on , requesting pain medication. The Service Recipient told her, "Three times I asked SHTA to get the nurse so I could get pain medication. Twice I was told, I'll get the nurse go back to bed. The last time I asked SHTA he slammed the door to my room in my face." (Justice Center Exhibit 4)

SHTA SHTA and SHTA were three of the other SHTAs who were assigned to the infirmary for the shift in question and who provided signed statements to Director .

SHTA did not recall hearing the Service Recipient request pain medication during the shift, although she had heard him make a similar request during a recent shift prior to the incident. (Justice Center Exhibit 12)

SHTA did not recall hearing the Service Recipient request pain medication during the shift, although she did hear him yelling and the sound of his room door slamming shut on the morning of . (Justice Center Exhibit 13)

SHTA provided a signed statement to Director and at the hearing he testified that, as he was preparing to assist a patient with a 7:00 a.m. shower, he saw the Service Recipient come out of his infirmary bedroom and ask the Subject, who was standing nearby in the hallway, to call the nurse for his medication, and that the Subject answered, "okay." SHTA testified further that he heard the Service Recipient yelling that morning. He also testified that, when he questioned the Service Recipient later that afternoon, the Service Recipient complained that he had asked for his pain medication and never received it the night before. (Hearing testimony of SHTA)

SHTA Hearing testimony was not entirely consistent with the statement that he provided to Director . (Justice Center Exhibit 10) However, he explained that he had originally sought to avoid getting the Subject "into trouble," by omitting the Subject's name in his written statement. (Hearing testimony of SHTA)

The Subject consistently denied having any interaction with the Service Recipient at all during the shift. In his verbal statement to Director , the Subject told her that he had no interactions with the Service Recipient during the morning in question. (Justice Center Exhibit 7)

On , the Subject provided a signed statement, again denying that the Service Recipient spoke to him at all that morning. (Justice Center Exhibit 9)

In his letter to the Justice Center, requesting an amendment to the substantiated allegation, the Subject again denied culpability. He referred to the matter as a "false allegation

of patient abuse," and indicated that he signed the Signed Memo of Written Counselling (Justice Center Exhibit 20) "under duress," having been "threatened." (Justice Center Exhibit 2)

At the hearing, the Subject testified that he did not receive any request from the Service Recipient for pain medication during the shift and, further, that he had no interaction whatsoever with the Service Recipient at any time during the shift. (Hearing testimony of ; Subject)

The Subject's counsel argued that for four hours, out of the eight-hour shift, the Subject was assigned as a 2:1 for another patient and that during that time, at least, it would have been impossible for the Service Recipient to have spoken to the Subject.

A review of the Assignment Sheets for that shift (Justice Center Exhibit 5) reveals that the Subject's 2:1 duties were from 11:00 p.m. to 1:00 a.m. and from 3:00 a.m. to 5:00 a.m., which are time periods that would not have precluded the Service Recipient from requesting pain medication from the Subject at 1:00 a.m., 2:00 a.m. and 6:00 a.m., as alleged.

The Subject's counsel argued that RN entry in the Service Recipient's Progress Notes (Justice Center Exhibit 17) stating that the Service Recipient, "slept through the night," establishes that the Service Recipient had not made the requests of the Subject, as alleged.

RN testified that she had assumed that the Service Recipient had "slept through the night" based on the fact that each time she looked in on the Service Recipient, during her rounds, he was lying in his bed and that no one had reported anything to her about him during the shift. (Hearing testimony of RN)

RN further testified that, while she did check on the Service Recipient as reflected in the SHTA Patient Room Check Form (Justice Center Exhibit 6) at 23:15, 00:05,

02:00, 04:00, 05:45 and 06:30, the room check procedure consisted of looking through the small window of the bedroom door without opening the door, entering the room or speaking to the Service Recipient. RN testified that when she looked in on the Service Recipient he was in bed, but that she did not know if he was awake or asleep. (Hearing testimony of RN)

In light of the cursory nature of RN bed checks, the evidence that she observed the Service Recipient to be lying in his bed, at the times written on the SHTA Patient Room Check Form, is not inconsistent with the Service Recipient having requested medication and being told by the Subject to go back to bed, as alleged.

The Subject introduced an undated two-page OMH Abuse Neglect Investigation Cover Page as evidence that Director had, at one point, concluded that the Service Recipient's allegations were unsubstantiated. The document contains some areas with boxes for short answers and some areas where there are choices, and the answer is selected with a checkmark in the box beside the desired response. In the box for Recommended Investigation Outcome, the answer "None" was typed. In the box for Recommended Investigation Category for Substantiated Offences, none of the four possible categories was selected and it was left blank. In the box providing a choice between Unsubstantiated and Substantiated, Unsubstantiated was selected. (Subject Exhibit 1)

When questioned about this, Director was unsure whether the document had been entered into the OMH database or if it had been "corrected." She was also unsure as to whether the document had been sent to the Justice Center or whether a "corrected" version had been generated. She did testify that it was always her intention to conclude that the Subject had

committed the neglect as alleged by the Service Recipient. (Hearing testimony of Director)

In any case, regardless of Director conclusions, the Justice Center conducts an independent review of all allegations in every Justice Center case and reaches its own determination as to whether the allegations are substantiated or not. In this case, it is clear that the Justice Center did substantiate the allegations.

With respect to the question of credibility, the weight of the Justice Center's evidence adds up to be significantly more persuasive than the Subject's blanket denial.

There is no evidence in the record of any motivation by the Service Recipient to fabricate his story. By all accounts, the Service Recipient and the Subject had no prior relationship, which might have provided the impetus for the Service Recipient to complain about the Subject. The Service Recipient's sincere outrage supports the veracity of his allegations against the Subject. The Subject, on the other hand, had the strong motivation of the preservation of his reputation and his employment status to compel him to prevaricate and deny. Furthermore, the Service Recipient's reports to the various staff members to whom he spoke on were clear, consistent, and credible, while the Subject's statements regarding what happened that early morning were not persuasive.

The preponderance of the evidence establishes that the Subject did commit the act(s) giving rise to the substantiated report, namely that he did, in fact, ignore repeated requests by the Service Recipient to ask the nurse to give him pain medication on .

Having determined that the Subject committed the act(s) as alleged, the next question is whether his conduct constitutes neglect.

All of the elements of neglect as set out in SSL § 488(1)(h) are present in this case. The Subject's conduct of ignoring repeated requests by the Service Recipient for the nurse to give him pain medication was a breach of his duty to the Service Recipient that resulted in "serious or protracted impairment of the physical, mental or emotional condition" of the Service Recipient. In this case, the impairment of the Service Recipient's physical condition was both serious and protracted. The Service Recipient had consistently requested pain medication from 1:00 a.m. until he received it at 7:15 a.m. It is reasonable to conclude that throughout that relatively prolonged period of over six hours, the Service Recipient was suffering pain. Furthermore, the fact that both the last dosage he had received prior to the shift and the first dosage he received after the shift were two pills, demonstrates that the pain the Service Recipient was experiencing was severe.

In the final analysis, based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed neglect as alleged in Offense 1 of the substantiated report.

Moreover, the category of the affirmed substantiated neglect that such act constitutes was properly substantiated as a Category 3 act. A substantiated Category 3 finding of abuse and/or 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 NY SSL § 496 (2). This report will be sealed after five years.

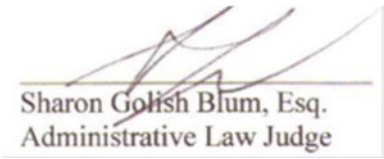
DECISION: The request of [redacted] that the substantiated report, dated [redacted], [redacted]

[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 neglect.

The substantiated report is properly categorized as a Category 3 act.

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

DATED: June 12, 2015
Plainview, New York



Sharon Golish Blum, Esq.
Administrative Law Judge