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 AMENDED

Adjud. Case #:
[redacted]

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

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

[redacted]
By: Constance R. Brown, Esq.
CSEA, Inc.
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224-0125

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 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: August 31, 2015
Schenectady, New York

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: Jean T. Carney
Administrative Law Judge

Held at: New York State Office Building
333 East Washington Street, Hearing Room 115
Syracuse, New York 13202
On: [redacted]

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

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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating (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:

Allegation 1

> It was alleged that on , at the , located at , while acting as a custodian, you committed neglect when you failed to properly supervise a service recipient by maintaining the assigned constant observation level of supervision.
>
> 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 was retained.

4. The facility, located at , is a Psychiatric Hospital operated by the 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 by OMH at since 1980; and was employed as a Mental Health Therapy Aide II (MHTA II) (Hearing testimony of Subject, Justice Center Exhibit 4).

6. The Service Recipient had been admitted to Treatment Unit three days prior to the date of the alleged neglect. He was 59 years old and was diagnosed with major depressive disorder, single episode, severe with psychotic features; anxiety disorder; AFIB; psoriatic arthritis; and hypertension (Justice Center Exhibit 12).

7. During his admission screening, the Service Recipient was placed on constant observation status due to his high risk of falling, his difficulty in following direction, and his diminished safety awareness regarding mobility (Justice Center Exhibit 14, Hearing testimony of Clinical Risk Manager (CRM)).

8. On , the Subject was assigned to constant observation of the Service Recipient from 3:00 p.m. until 4:00 p.m. (Hearing testimony of Subject, Justice Center Exhibit 5). Also during that time, the Service Recipient's brother arrived for a visit (Justice Center Exhibit 4, Hearing testimony of CRM , Hearing testimony of Subject).

9. The Subject noticed that the Service Recipient had what appeared to be dried food on his face and sleeve. The Service Recipient's brother was trying to clean it up with a tissue, so the Subject volunteered to get a washcloth (Hearing testimony of Subject). In order to get a washcloth, the Subject had to leave the dining room where the visit was occurring, go down a hall to the other side of the building, into a closet to get the washcloth, then into another room to squirt soap and moisten the cloth, then go back to the dining room with the wet cloth (Hearing

testimony of Subject, Hearing testimony of [redacted], Justice Center Exhibits 2, 4, 7, 8, 9, and 20).

10. The Subject left the Service Recipient a total of four times between 3:00 p.m. and 4:00 p.m. He went two times for a clean washcloth, and he went to the refrigerator room twice for juice (Hearing testimony of Subject).

11. Earlier in the day the charge nurse had expressed concern regarding the Service Recipient's ability to urinate. She had discussed inserting a catheter; but the Service Recipient had assured her that he would be able to urinate on his own (Hearing testimony of Subject, Justice Center Exhibit 2). As a result of that earlier conversation, the Subject concluded that pushing fluids would be beneficial to the Service Recipient. Subsequent to bringing the second washcloth to the Service Recipient's brother, the Subject decided to get the Service Recipient some juice. The Subject then gestured for the nurse to come over to discuss this condition with the Service Recipient and his brother (Hearing testimony of Subject). However, he neither explained his thought process to the nurse, nor did he ask her to take over his duty of constant observation of the Service Recipient (Hearing testimony of Subject).

12. The relevant OMH policy in effect at the time clearly defines constant observation as continuous visual contact, even when the patient is visiting someone (Justice Center Exhibit 19). The Subject knew that he was assigned to the Service Recipient during the relevant time; and that the Service Recipient was under constant observation (Justice Center Exhibits 2, 5, 6, and 12).

13. The Subject was able to accurately describe his duties under the constant observation policy, and demonstrate an understanding of what was expected of him (Justice Center Exhibit 20).

ISSUES

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

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of 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 "Allegation 1" in the substantiated report. The act committed by the Subject constitutes neglect.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation (Justice Center Exhibits 1-19). In addition, the Justice Center presented an audio recording (Justice Center Exhibit 20). The investigation underlying the substantiated report was conducted by CRM , who was the only witness who testified at the hearing on behalf of the Justice Center. The Subject testified on his own behalf and provided several documents (Subject Exhibits A and B).

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect when he left the Service Recipient to whom he was assigned, and who was on constant observation status.

In order to make a prima facie case of neglect, the Justice Center must show that the Subject breached his duty to the Service Recipient through "any action, inaction or lack of attention…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…" Social Services Law §488(1)(h).

The uncontroverted proof in this case is that the Service Recipient was placed under constant observation status due to his frailty, impetuous behavior, and lack of insight regarding his own limitations (Justice Center Exhibit 14). The Subject was aware of this status, and fully understood what was required when assigned to a patient under constant observation status (Justice Center Exhibit 5, Hearing testimony of Subject). It is also uncontroverted that the Subject was assigned to the Service Recipient from 3:00 p.m. until 4:00 p.m. on (Justice Center Exhibit 5). Therefore the Subject had a duty to keep the Service Recipient under constant observation for that hour.

Nevertheless, the Subject decided to leave his charge on no less than four occasions during that hour (Hearing testimony of Subject). While his intentions may have been good, that does not ameliorate the fact that he breached his duty to the Service Recipient. The moment the Service Recipient was no longer within visual range, the Subject violated OMH policy, and therefore failed to provide proper supervision to the Service Recipient (Justice Center Exhibit 19).

In his defense, the Subject asserted that there was other staff present that could have prevented the Service Recipient from coming to harm while he was gone (Hearing testimony of Subject). However, the Subject neither asked any of those co-workers to step in for him while he went out of the room; nor did he alert them that he was leaving his patient (Justice Center Exhibit 20). Furthermore, the other staff had other duties and responsibilities that may very well have prevented them from keeping track of the Subject and the Service Recipient. The Subject was responsible for one thing only: to keep this Service Recipient under constant observation.

The Subject also asserted that the Service Recipient was in no danger because his wheelchair was locked and pushed up against the table; and the Service Recipient's brother was

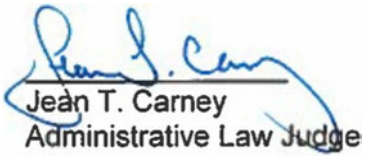
present (Hearing testimony of Subject). None of these assertions relieved the Subject of his duty to maintain constant observation of the Service Recipient. The Subject breached that duty, and given the Service Recipient's condition, it was likely that he could have been injured while unsupervised.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

Because the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category level of abuse or neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence and the testimony presented; it is determined that the substantiated report is properly categorized as a Category 3 act.

DECISION: The request of that the substantiated report dated , received and dated 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 Jean T. Carney, Administrative Hearings Unit.

DATED: July 15, 2015
Schenectady, New York