

**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**

Adjud. Case #:

██████████

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

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

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██████████
By: Nicole Murphy, Esq.
Fine, Olin & Anderman, LLP
39 Broadway, Suite 1910
New York, New York 10006

██████████
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 ██████████
██████████, ██████████ 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: February 4, 2016
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

██████████

Pursuant to § 494 of the Social Services Law

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjudication Case #:

██████████

Before:

Sharon Golish Blum
Administrative Law Judge

Held at:

Adam Clayton Powell State Office Building
163 West 125th Street
New York, New York 10027
On: ██████████

Parties:

Vulnerable Persons' Central Register
New York State Justice Center for the Protection
of People with Special Needs
161 Delaware Avenue
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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 VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a substantiated report dated [REDACTED], [REDACTED] of neglect by the Subject of a Service Recipient.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Allegation 1

It was alleged that on [REDACTED], while in the classroom in House [REDACTED] at the [REDACTED], located at [REDACTED], while acting as a custodian, you committed neglect when you failed to provide adequate supervision to a service recipient when you failed to follow the service recipient's diet plan.

This allegation has been SUBSTANTIATED as Category 3 neglect, pursuant to Social Services Law § 493(4)(c).

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

4. The facility, [REDACTED], located at [REDACTED], is a secure treatment residence for people with developmental disabilities and psychiatric diagnoses, and is

██████████ operated by the New York State Office for People With Developmental Disabilities (OPWDD), 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 facility was composed of a campus and a number of residential units, including Houses ██████████, each having separate service recipients and assigned staff. (Justice Center Exhibit 6)

6. At the time of the alleged neglect on ██████████, the Subject, who had been employed as a Direct Support Assistant (DSA) by the facility for approximately fifteen years, was regularly assigned to work the night shift in House █. On ██████████, the Subject was assigned an overtime day shift in House █, which involved supervising service recipients, including the Service Recipient, in Classroom ██████████. (Hearing testimony of the Subject and Justice Center Exhibit 16: audio interrogation of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

7. At the time of the alleged neglect, the Service Recipient was a fifty-two year old resident of the facility's House █. The Service Recipient is a person with a diagnosis of profound mental retardation, together with numerous physical health issues. The Service Recipient is non-verbal and although he is ambulatory, he is blind and completely dependent, requiring assistance with all of his activities of daily living. (Justice Center Exhibit 17)

8. Due to the risk of "silent aspiration" (the asymptomatic ingestion of fluid into the lungs), the Service Recipient's dietary plan requires that all of his drinks be thickened with a prescribed powder to a honey-like consistency. (Hearing testimony of OPWDD Investigator ██████████¹ and Justice Center Exhibits 9, 12, 13 and 14)

¹ At the time of the investigation, ██████████ was an OPWDD Investigator and she has since transferred to another position. For the purpose of this determination, she will be referred to as OPWDD Investigator ██████████.

9. At approximately 2:00 p.m. on [REDACTED], in Classroom [REDACTED], the Subject, who was assisting in the supervision and care of a number of service recipients, including the Service Recipient, provided the Service Recipient with a drink of juice that had not been thickened and helped him to drink it. (Hearing testimony of the Subject and Justice Center Exhibits 7, 8 and 16: audio interrogation of the Subject)

10. Subsequent to the incident, all of the DSAs, including the Subject, were provided in-service training regarding the Service Recipient's need to have his drinks thickened. The training ended with the DSAs, including the Subject, signing an acknowledgement on a notice to staff of the Service Recipient's drink thickening needs. The acknowledged notice was thereafter posted conspicuously in facility Classroom [REDACTED]. (Hearing testimony of the Subject and OPWDD Investigator [REDACTED])

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 allegation constitutes 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 neglect presently under review was substantiated. A "substantiated report" means a report "wherein a determination has been made

as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred..." (Title 14 NYCRR 700.3(f))

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1). Under SSL § 488(1)(h) neglect is defined as:

"Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3 which is defined as follows:

(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.

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).

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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 the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed the act described as Allegation 1 in the substantiated report. Specifically, the evidence establishes that the Subject committed an act of neglect under SSL § 488(1)(h) in that the Subject's actions and lack of attention, by failing to thicken the Service Recipient's drink, breached her duty to the Service Recipient, which was likely to result in serious or protracted impairment of his physical condition.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-18) The investigation underlying the substantiated report was conducted by OPWDD Investigator ██████████, who testified at the hearing on behalf of the Justice Center.

The Subject testified at the hearing on her own behalf and provided no other evidence.

The Justice Center contended that the Subject committed neglect when she failed to follow the Service Recipient's dietary plan, which includes a requirement that all drinks provided to the Service Recipient be thickened with a powder to a honey-like consistency to prevent him from silently aspirating fluid into his lungs.

The Subject's defense to the allegation of neglect was that the Subject did not normally

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provide care to the Service Recipient and that she had not been given any notice of the requirement that his drinks be thickened. A further assertion emerged from the Subject's interrogation responses and her hearing testimony to the effect that, at the time of the incident, the Subject was overwhelmed and distracted and, as a result, had inadvertently overlooked the Service Recipient's dietary requirement.

In support of the Subject's position that she had not been made aware of the Service Recipient's drink thickening requirement, much of the evidence showed that the Subject had not been provided with either verbal or written notice of the requirement. Subsequent to the incident, all of the DSAs were provided training regarding this requirement, which ended with the DSAs signing an acknowledgement of having received the training. The fact that the signed document was thereafter posted conspicuously in facility Classroom ██████████ further supports the Subject's assertion that there had been a failure by the facility to adequately train direct care staff members, including the Subject, regarding the Service Recipient's drink thickening dietary requirement. Lastly, it was apparent that although there were written records reflecting the Service Recipient's need to have only thickened drinks, these documents were maintained in areas that were essentially inaccessible to the Subject. (Hearing testimony of OPWDD Investigator ██████████)

Regardless of the lack of proof of both notice to and training of the Subject, the evidence established that at the time that the Subject gave the Service Recipient the untreated drink, she was aware of the Service Recipient's drink thickening requirement. The Subject's answers to OPWDD Investigator ██████████ questions, during the ██████████ interrogation, belie the argument that she did not know of the Service Recipient's need to have his drinks thickened. The Subject was asked by OPWDD Investigator ██████████ five times as to

whether or not she was aware of the Service Recipient's drink thickening requirement at the time of the incident. The first time, the Subject answered that she was "vaguely" familiar with the thickening requirement, that she knew that she had "overlooked" the thickener, and that she had "accidentally" failed to follow the requirement, claiming that it was a busy morning and that she had been distracted. The second time that the Subject was asked if she knew before the "in-service" training that the Service Recipient required the thickener, the Subject reiterated that she was distracted and that there was insufficient staffing with her at the time. She then stated that the only thing she could think of was that she had accidentally overlooked putting the thickener in his drink. The third time that the Subject was asked if she knew before the in-service training that the Service Recipient required the thickener, the Subject had difficulty formulating a response and then stated that she was probably just distracted at the time and did not realize she had failed to follow the requirement. The fourth time that the Subject was asked about her prior knowledge of the Service Recipient's drink thickening requirement, the Subject stated that she only works with the Service Recipient on overtime shifts and that, therefore, she was not always with him. The Subject then added that because she had been more concerned with managing the behaviors of both the Service Recipient and another service recipient, she gave him the liquid and "didn't focus on... (the thickener requirement.)" In the fifth inquiry about the Subject's prior knowledge, OPWDD Investigator ██████████ asked the Subject whether she had overlooked or was not aware that the Service Recipient required thickener. The Subject responded that "It was a little bit of both." (Justice Center Exhibit 16: audio interrogation of the Subject)

The Subject's hearing testimony began with an assertion that she was not aware on the date of the incident that the Service Recipient's drinks were required to be thickened. The Subject maintained that position at the start of her cross examination as well. However, the

Subject then admitted that she remembered that in the past she had thickened the Service Recipient's drink. The Subject then admitted that she may have made an error on the day in question. (Hearing testimony of the Subject)

The Subject repeatedly explained, in her interrogation responses, and in her hearing testimony, that because so much was going on at the time she had given the Service Recipient an unthickened drink, she had been overwhelmed and distracted, and as a result, she inadvertently overlooked the drink thickening requirement. The Subject's explanations may be true, but her admissions of distraction, inadvertence and error are not valid defenses to the allegation of neglect.

Through the Subject's admissions, both in her interrogation responses and her hearing testimony, it is concluded that on [REDACTED], the Subject was aware of the Service Recipient's drink thickening requirement, and despite her knowledge of the requirement, the Subject gave the Service Recipient a drink that was not thickened. The Subject's conduct therein constitutes a breach of her duty to the Service Recipient.

The purpose of the requirement, that the Service Recipient's drinks be thickened, is to prevent the Service Recipient from silently aspirating liquid, which may be very dangerous to him while undetectable to others. Accordingly, the Subject's breach of duty was likely to result in physical injury or serious or protracted impairment of the physical condition of the Service Recipient.

Accordingly, 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 the neglect under SSL § 488(1)(h), as specified in Allegation 1 of the substantiated report.

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The report will remain substantiated. The next issue to be determined is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented and the witnesses statements, it is determined that the substantiated report is properly categorized as a Category 3 act. 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 ██████████ that the substantiated report 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 Sharon Golish Blum, Administrative Hearings Unit.

DATED: February 1, 2016
Plainview, New York


Sharon Golish Blum, Esq.
Administrative Law Judge