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

Adjudication Case #: [redacted]

:

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: Roger Linden, Esq.
Cappello Linden & Ladouceur
76 Market Street
PO Box 5153
Potsdam, NY 13676

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

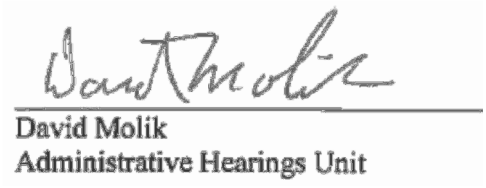
ORDERED: The request of [redacted] that the substantiated report [redacted], be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated report is properly categorized, or should be categorized as a level four category.

NOW THEREFORE IT IS DETERMINED that this report shall require, "the facility or provider agency to develop and implement a plan of prevention and remediation of the deficient conditions," and all other requirements, pursuant to SSL § 493(4)(d) and (5)(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
May 30, 2014



IF YOU DID NOT WIN YOUR HEARING, YOU MAY APPEAL TO THE COURTS PURSUANT TO THE PROVISIONS OF ARTICLE 78 OF THE CIVIL PRACTICE LAW AND RULES. IF YOU WISH TO APPEAL THIS DECISION, YOU MAY WISH TO SEEK ADVICE FROM THE LEGAL RESOURCES AVAILABLE TO YOU (E.G., YOUR ATTORNEY, COUNTY BAR ASSOCIATION, LEGAL AID, OEO GROUPS, ETC.) SUCH AN APPEAL MUST BE COMMENCED IN STATE SUPREME COURT WITHIN FOUR MONTHS AFTER THE DETERMINATION TO BE REVIEWED BECOMES FINAL AND BINDING. AN APPEAL IS NOT COMMENCED BY WRITING TO THIS OFFICE OR ANY OFFICE OR OFFICIAL OF THE NEW YORK STATE JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS, INCLUDING THE VULNERABLE PERSONS' CENTRAL REGISTER.

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjudication Case #: [redacted]

Before: Diane Herrmann
Administrative Law Judge

Held at: John H. Hughes State Office Building
333 East Washington St
Syracuse, NY 13202
On: [redacted]

Parties: 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: Roger Linden, Esq.
Cappello Linden & Ladouceur
76 Market Street
PO Box 5153
Potsdam, NY 13676

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, [redacted], is not a subject of the substantiated report. The Justice Center 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, [redacted], of a category 4 level of neglect by the Subject.

2. The initial report alleges, in pertinent part, that: [redacted] failed : (1) to provide clear protocols relative to how the living room was to be supervised by staff and more specifically, the failure to take any steps to end the common practice of staff leaving the living room unsupervised, and, (2) to have proper supervision levels in place for service recipient [redacted]., who at the time of the above incident had a history of inappropriate sexual/physical contact with other residents.

3. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).

4. The Justice Center substantiated the report against the Subject as a category level four of neglect.

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

was retained.

6. At the time of the alleged abuse and/or neglect, service recipient [redacted] was a resident at the [redacted] at the [redacted]

7. On the evening of [redacted], the service recipient was in the living room of the [redacted] home with eight other service recipients.

8. Five staff members were on duty but only one staff member was present in the living room.

9. The staff member left the living room to go into the adjacent laundry room.

10. While in the laundry room the staff member heard one of the residents make loud vocalizations and she exited the laundry room.

11. When the staff member entered the living room she found [redacted] on top of another service recipient (victim). [redacted] was making thrusting motions.

12. The staff member told [redacted] to get off the victim and he failed to do so. The staff member then pulled [redacted] off the victim.

13. Staff members examined both [redacted] and the victim. [redacted] was found to have what was presumed to be ejaculate in his underwear. The victim did not have any injuries.

14. [redacted] is a person with limited vocabulary and profound cognitive delays. [redacted] can ambulate but has an unsteady gait and typically moves in a wheelchair.

15. The victim is a person who is nonverbal and has profound cognitive delays and cannot ambulate.

16. [redacted] moved into the house in [redacted] and prior to [redacted] there were at least three documented incidents of inappropriate contact involving [redacted] and other service recipients.

17. The first documented case occurred on [redacted]. At 3:00 AM a motion sensor went off in a hallway outside [redacted] room. The staff member who responded found [redacted] in a female service recipient's room laying on top of her and making thrusting motions.

18. This victim could vocalize but was nonverbal so she could not describe what happened. Staff indicated that she was crying after the incident. A body check was completed and no injuries were found.

19. [redacted] completed an investigation. The investigator's report indicated that he was told by staff that this was not the first time that [redacted] had entered other residents' bedrooms. The investigator found that on [redacted], [redacted] entered a resident's room.

20. As a result of the investigation [redacted] added a motion detector alarm on [redacted] bedroom door.

21. The next documented incident happened on [redacted]. At 10:00 PM two [redacted] staff members found [redacted] in the hallway outside his room and the door to the bedroom directly across from [redacted] open. The staff was positive that the bedroom door across from [redacted] had been closed so they entered the room and asked the resident if [redacted] had entered his bedroom.

22. The service recipient indicated that [redacted] had entered his room and gotten on top of him. In a follow-up interview he stated that [redacted] was "screwing him." The events of [redacted] occurred in the same bedroom which [redacted] entered on [redacted]. (See Exhibit JC 27)

23. Staff members checked the motion detector in [redacted] room and found that it was not mounted correctly. The Agency fixed the monitor and added an additional alarm on the

door.

24. After the [redacted] incident, [redacted] bedroom was moved to a location more conducive to monitoring. Staff activities were also altered so that noises like vacuuming would not impede the staff's ability to hear the alarms on service recipients' rooms.

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 or neglect in residential care facilities. SSL § 492(3) (c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse or neglect presently under review was substantiated. A "substantiated report" means a report made "… if an investigation determines that a preponderance of evidence of the alleged neglect and/or abuse exists."

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse or neglect; and pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

The abuse and neglect of a person in residential care is defined by SSL § 488:

"Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:

(a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

(b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

(c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes

of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through

(g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the subject committed the act or acts of abuse or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category level of abuse and neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

    (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

        (i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;
        (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse

practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;
(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;
(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;
(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;
(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;
(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;
(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;
(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;
(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and
(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.

(c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of abuse cited in the substantiated report constitutes the category level of abuse set forth in the substantiated report. If the Justice Center did not prove the abuse by a preponderance of evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of evidence that [redacted] lack of action constituted neglect and the proper level is a category four.

In support of its indicated findings, the Justice Center presented case notes and documents gathered during the course of investigation. The Justice Center called one witness, the investigator. The Appellant called two employees of the [redacted] home as witnesses, and admitted photos of the location and resident nursing care and behavior plans for the service recipients.

To prove a Category four level of neglect the Justice Center needs to show that conditions at the facility 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.

The Justice Center's witness was [redacted] who is employed by [redacted] as a Quality Assurance worker. [redacted] completed the investigation into all three incidents. [redacted] testified that the first incident happened in the evening when [redacted] left his room and entered the bedroom directly across from his. The staff was alerted to the incident when they heard a motion detector go off in the hallway. When staff responded, they found [redacted] on top of a female resident making thrusting motions.

Staff members checked the motion detector in [redacted] room and found that it was not mounted correctly. The Agency fixed the monitor and added an additional alarm on the door.

Despite these measures [redacted] was able to leave his room undetected on another occasion. On [redacted] staff members responded to a motion detector in the hall by several service recipients' bedrooms and found [redacted] in the hallway. The staff escorted him back to his room and discovered the door to the bedroom directly across from [redacted] open. The staff said that they knew the bedroom door had been closed when they last checked the area and the resident had been put to bed. The staff entered the room to speak to the service recipient.

The service recipient told the staff that [redacted] entered his room and lay on top of him. The next day the service recipient told staff that [redacted] was screwing him.

After this incident the staff moved [redacted] room so that he was located in a location more conducive to monitoring.

The Subject's witness spoke at length as to the measures the agency took after each incident. These measures included: checking and adding alarms to his bedroom and then eventually moving his bedroom. [redacted] also altered the times that staff vacuumed the living areas so that they could more closely monitor the motion detectors and alarms.

The Agency focused on the fact that the prior incidents were different because the prior incidents happened after [redacted] was put to bed. The Agency said that [redacted] was the first incident that happened during day or evening hours.

What is striking is that the three incidents happened when [redacted] was left alone and unsupervised. The Agency made changes to how [redacted] was monitored at night when he was in his bedroom. The measures did not include supervising [redacted] when he was with other service recipients during daytime hours. After the third incident [redacted] put policies in place so that [redacted] was not left alone with other service recipients, could not be within arm's reach of other service recipients and had to be within eye sight of staff.

The Agency witnesses testified that the [redacted] location is [redacted] home and he should be free to move about his home and not be subject to extraordinary security measures. The subject witness stated that it was not a prison but a home and service recipients should be free to move about.

The Agency needs to balance [redacted] freedom with the safety and security of the other residents. Prior to [redacted], the Agency policies and procedures left the service recipients in

the home vulnerable because [redacted] was unsupervised during the day. A review of the [redacted] Statement of Residents Rights reveals that the first right is the right to a safe and sanitary environment (Exhibit JC 35). [redacted] climbed on top of three different service recipients.

After the first sexualized incident which [redacted] engaged in, the Subject was on notice of [redacted] propensity to commit such acts and should have ensured appropriate supervision of [redacted] at all times. Each of these incidents occurred when there was no staff supervision. In each of the incidents [redacted] was able to leave his wheelchair and walk across a room, and/or hall and climb on top of someone else. The three service recipients did not have the capacity to consent and only one of three was able to verbally express what happened. Clearly, the service recipients of the [redacted] location are at risk if [redacted] is allowed to move about at will.

[redacted] also argued that the Justice Center had no authority to make a category four finding against the agency when the neglect claim against the staff members was unsubstantiated. The Justice Center rejected this interpretation of the statute. The Justice Center is correct; the statute clearly allows a category four finding when individual culpability is mitigated by systematic problems at a facility. The fact that the individuals were unsubstantiated does not negate a finding against a facility.

The Agency proved by a preponderance of the evidence that the provider agency exposed the service recipients to harm or risk of harm where staff culpability was mitigated by systemic problems such as inadequate management, staffing, training or supervision.

Accordingly, it is determined that the Agency has met its burden of proving by a preponderance of the evidence that the report is substantiated, and will therefore not be amended or sealed.

DECISION: The request of [redacted] that the substantiated report [redacted], be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated report is properly categorized, or should be categorized as a level four category.

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

DATED: Schenectady, New York

_____
Diane Herrmann, ALJ