

**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: Tracy Steeves, Esq

[REDACTED]

[REDACTED]

[REDACTED]

By: [REDACTED]

[REDACTED]

[REDACTED]

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

ORDERED:

The Subject, [REDACTED] has not been shown by a preponderance of the evidence to have committed abuse and/or neglect as contained in the substantiated report [REDACTED], dated [REDACTED].

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

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: Schenectady, New York
October 31, 2014



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

**RECOMMENDED
DECISION
AFTER
HEARING**

Pursuant to § 494 of the Social Services Law

Adjud. Case #:

Before:

Gerard D. Serlin
Administrative Law Judge

Held at:

West Seneca DDSO
1200 East and West Road
Building 16
West Seneca, NY 14224
On: [REDACTED]

Parties:

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

[REDACTED]
[REDACTED]
[REDACTED]
By: [REDACTED]
[REDACTED]
[REDACTED]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating (the Subject) for 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 [REDACTED] dated [REDACTED] of neglect by the Subject of [REDACTED]

2. The initial report alleges generally that:

Since [REDACTED], that the service recipient has had several falls from bed and staff has failed to take steps to prevent those falls, including a fall out of her bed on [REDACTED] that required her to be taken to the emergency room until [REDACTED]¹.

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

4. On or about November 1, 2013, the Justice Center Substantiated the report against the Subject for neglect. The Justice Center concluded that:

It was alleged that on dates on and before [REDACTED], at the [REDACTED] [REDACTED], located at [REDACTED], while acting as a custodian (behavioral clinician), you neglected a service recipient. Specifically, you were aware, since [REDACTED], that the service recipient required protective measures after the she fell out of her bed numerous times, but you failed to take steps to prevent those falls, including a fall out of her bed on [REDACTED] [REDACTED] that required her to be taken to the emergency room, until [REDACTED]

¹ There were other allegations related to the Subject falling from her motor scooter, outside of the [REDACTED] Those allegations did not result in a Substantiated report.

114

5.

6.

7.

8.

9.

2

policy. When a service recipient falls to the ground, EMS is called and an assessment is done by EMS. Staff will not assist a service recipient with getting to an upright position, this task must be completed by EMS. After each fall, the service recipient was strongly encouraged to go to the hospital for a medical evaluation. (Justice Center Exhibit 25: recorded interview with [REDACTED]-*Site Manager*) On [REDACTED] and [REDACTED] was transported to the hospital for a medical evaluation, after she fell from bed. (Justice Center Exhibit 5)

10. On or about [REDACTED], and at the request of *Site-Manager* [REDACTED], a physician issued a script for “bed rails” for [REDACTED] (Justice Center Exhibit 18) During a meeting on or about [REDACTED], [REDACTED] learned that bed rails were a “rights restriction.” [REDACTED] began working for [REDACTED] in [REDACTED]. (Justice Center Exhibit 25: recorded interview with [REDACTED]-*Site Manager*)

11. Up until, on or about, [REDACTED] received Physical Therapy (P.T), but because [REDACTED] refused appointments, she was discharged by P.T. (Justice Center Exhibit 6, p 8) When the falling began in [REDACTED] utilized either the wheel chair or motorized scooter to ambulate on an-as-needed basis. However, by the time of the report in [REDACTED] [REDACTED] utilized her wheel chair or scooter to ambulate, most of the time.³ [REDACTED] was capable of transferring herself from the bed or the toilet, to her wheel chair or scooter. [REDACTED] utilized a motorized scooter to transport her-self off premise and to navigate without supervision away from the [REDACTED] for up to an hour, at a time. [REDACTED] often traveled unsupervised to a local 7-11 convenience store and *K-Mart*. (Agency Exhibit 25: recorded interview with [REDACTED]-*Site Manager*)

³ Much of the evidence in the record suggests that in the six to twelve months preceding the Justice Center investigation, [REDACTED] overall health and her ability to ambulate without assistance, greatly declined.

12. The [REDACTED] where [REDACTED] resided was, pursuant to regulations promulgated by the NYS Office for the Protection of People with Developmental Disabilities (OPWDD)⁴ and [REDACTED] internal policies, required “to review and approve Behavior Support Plans that employ the use of restrictive/intrusive techniques and/or medication used to prevent or control challenging behavior....” (ALJ Exhibit 1) Under the policy interpretation utilized by [REDACTED] bed rails could not be installed on [REDACTED] bed until the Care Review Committee (*the committee*), recommended same. Implementation of bed rails is a “rights restriction” and requires *committee* approval. Bedrails were generally frowned upon by OPWDD. (Hearing Testimony of [REDACTED], Director of residential services [REDACTED])

13. [REDACTED] also promulgated an internal policy entitled: *Bed Assessment and Bed Safety*. The policy required [REDACTED] staff to “[c]onsider [...] and recommend the least restrictive bed setup for a person other than bedrails, whenever possible...” The policy further dictated that a *Risk Profile Checklist* was to be completed whenever an “individual’s condition has changed.” Pursuant to this policy, the *Site Manager* was obligated to notify the *Registered Nurse* and *Quality Assurance Coordinator* upon receipt of orders for bed modification. The policy placed the obligation on the [REDACTED] *Quality Assurance Coordinator* (CQI), to “verif[y] that the necessary safeguards have been put into place for the individual.” (Justice Center Exhibit 8)

14. The *Program Manager-Coordinator* [REDACTED] contacted CQI and requested clarification as to whether bed rails needed to be approved by *the committee*. (Justice Center Exhibit 25: recorded interview with [REDACTED]-*Program Manager-Coordinator*) CQI responded that they were uncertain but opined that if the falls were “behavioral” as opposed to “medical” in origin, then bed rails were a “rights restriction.” (Justice Center Exhibit 25: recorded interview with [REDACTED]-*Program Manager-Coordinator*)

⁴ See 14 N.Y.C.R.R Section 633.16)

15. [REDACTED] was then tasked with a directive, by e-mail dated [REDACTED] from CQI [REDACTED], to organize a team (*the team*), of [REDACTED] care providers to evaluate and make recommendations on bed rails, ostensibly to *the committee*. The proposed *team* members were to include the Subject. (Justice Center Exhibit 22: e-mail of [REDACTED] [REDACTED])

16. Under [REDACTED] custom and practice *the team* was required to assemble and review the physicians script for bedrails, physician notes, nurse bed safety check list⁵, bedrail purchase request, and further to evaluate the possibility of other less restrictive means, including utilizing a prescribed checklist. Once the team completed these tasks, the Subject in her role as a *Behavior Clinician* was then required to submit this documentation to the *committee* for consideration of the bedrail request. (Hearing testimony of Subject and [REDACTED], Director of residential services [REDACTED] *The team* never had a formal meeting to discuss the issue. (Hearing testimony of the Subject) The obligation to assemble *the team* typically fell to the *Site Manager*, or if unavailable, to the *Program Manager-Coordinator*, [REDACTED] (Hearing testimony of [REDACTED] [REDACTED], Director of residential services [REDACTED])

17. At the onset of the falls in [REDACTED], [REDACTED] told [REDACTED] that she was falling because her legs hurt when she tried to get out of bed. [REDACTED] refused a neurological medical appointment at that time. From on or about [REDACTED] and continuing until [REDACTED] [REDACTED] refused to have necessary weekly blood work completed. (Agency Exhibit 25: recorded interview with [REDACTED]-*Site Manager*)

⁵ [REDACTED] own internal policy entitled: *Bed Assessment and Bed Safety* dictates that a *Risk Profile Checklist* was to be completed whenever an “individual’s condition has changed”. This policy outlines specific obligations for the *Site Manager*, [REDACTED] and the *CQI coordinator*. The policy squarely places the obligation on the facility *Registered Nurse* to “consider and recommend [...] the least restrictive bed set up for the person[,] other than handrails whenever possible...” However, the policy does not contemplate any action by, or dictate any role of, the *Behavioral Clinician* in the process of bed safety recommendations or modifications. (Justice Center Exhibit 8)

18. In [REDACTED] consented to a neurological consult and the neurologist concluded that there was no identifiable reason for [REDACTED] to have leg pain. (Justice Center Exhibit 25: recorded interview with [REDACTED] *Site Manager*)

19. After the bed-rail script was written on [REDACTED] indicated that she was falling from bed while reaching for items, such as food or the remote control. (Justice Center Exhibit 25: recorded interview with [REDACTED] *-Site Manager*)

20. Beginning in [REDACTED] or [REDACTED] and continuing until [REDACTED], [REDACTED] implemented a *safety plan* based upon the service recipient's feedback. The service recipient had a cell phone which she was very fond of using. [REDACTED] was instructed to phone staff for assistance with bringing items to her, in her bed. (Justice Center Exhibit 25: recorded interview with [REDACTED] *Site Manager*) [REDACTED] often ate in bed and had no dietary restrictions. [REDACTED] stored food on the floor and in the bed. [REDACTED] had the capability of buying her own food at the store (Justice Center Exhibit 25: recorded interview with [REDACTED] *Site Manager*) [REDACTED] often rolled from bed while reaching for food. Despite instructions from staff, [REDACTED] did not ask staff for help in obtaining food and other items. [REDACTED] continued to retrieve these items without assistance. (Justice Center Exhibit 25: recorded interview with [REDACTED] *service recipient*) Staff also repositioned [REDACTED] bed by placing the bed up against the wall to limit the number of sides from which [REDACTED] could roll to the floor. (Justice Center Exhibit 22: e-mail of [REDACTED] and Justice Center Exhibit 25: recorded interview with [REDACTED] *Site Manager*) Despite the implementation of minimally restrictive efforts, [REDACTED] continued to fall, or roll from bed.

21. As of [REDACTED] it became apparent to the *Site Manager* that actually implementing a bedrail script required a very high threshold. Essentially all alternatives to bed

rails were to be exhausted-first. Some personnel at [REDACTED] took that position that bedrails were never allowed, under any circumstances. Other staff in management positions took the position that bedrails were only allowed if the “falling” resulted from a medical problem, as opposed to a behavioral problem. (Justice Center Exhibit 22: e-mail of [REDACTED] and Justice Center Exhibit 25: recorded interview with [REDACTED]-Site Manager)

22. On or about [REDACTED], an employee of unknown title and position at [REDACTED] day program suggested to [REDACTED], that a floor mat could be placed into service, beside [REDACTED] bed. (Justice Center Exhibit 22: e-mail of [REDACTED]) As of [REDACTED] was resistant to the implementation of a floor mat, anti-roll mattress and bedrails. In [REDACTED] [REDACTED] visited another site where service recipients of similar needs resided; at this sight [REDACTED], viewed in-service floor mats, in furtherance of her research. On or about [REDACTED] [REDACTED] told those in attendance at [REDACTED] monthly ISP meeting that she was researching a floor mat. (Justice Center Exhibit 6-note entry [REDACTED]) [REDACTED] viewed the floor mat as a viable non-intrusive short term safety measure (Justice Center Exhibit 25: recorded interview with [REDACTED]-Site Manager).

23. On or about [REDACTED] or [REDACTED], [REDACTED] implemented 20 minute bed checks for [REDACTED]. This was a change from the one hour bed checks which were previously in place. (Justice Center Exhibit 6 and Justice Center Exhibit 25: recorded interview with [REDACTED]-Site Manager)

24. Initially [REDACTED] sent a request intra-agency seeking an existing floor mat to be placed into service, on a trial basis. No floor mat was available and a purchase requisition was requested by [REDACTED] for a floor mat. On or about [REDACTED] this purchase request was

denied by [REDACTED] supervisor, the program coordinator, [REDACTED]⁶ who conveyed to her that, an in-home assessment on the viability of an anti-roll mattress should be conducted instead. (Justice Center Exhibit 25 & Justice Center Exhibit 25: recorded interview with [REDACTED]-*Site Manager*)

25. The assessment was completed and on [REDACTED], [REDACTED] submitted the purchase requisition for the anti-roll mattress. The requisition was approved and the mattress was delivered to the [REDACTED], on or about [REDACTED]. When the anti-roll mattress was implemented [REDACTED] expressed her displeasure with the mattress because it “sucks the patient” into the bed. On or about [REDACTED], a request for the floor mat was re-submitted by [REDACTED], and the request was approved. At least as of the time of the investigation, [REDACTED] continued to maintain authority to consent to, or to refuse medical treatment. The *Site Manager* was of the opinion that [REDACTED] continued to maintain the authority to refuse the mattress and floor mat, or direct the removal of same. (Justice Center Exhibit 25: recorded interview with [REDACTED]*Site Manager*)

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.

⁶ Neither the anti-roll mattress, nor the floor mat, was a cost which was paid for by *Medicaid*. [REDACTED] was required to pay the cost out-of- pocket. (Justice Center Exhibit 25: recorded interview with [REDACTED] – *Site manager*) After seeking approval for the purchase of a floor mat, the *Program Coordinator* received a phone call from [REDACTED] (*Assistant Director* of [REDACTED] on or about [REDACTED], who advised her that a quote should be obtained for an anti-roll mattress and **not** a floor mat. (Justice Center Exhibit 25: recorded interview with [REDACTED]*Program Manager-Coordinator*)

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:

- 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 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 not established by a preponderance of evidence that the Subject committed the neglect alleged in the substantiated report.

In support of its indicated findings, the Justice Center presented the VPCR report, the narrative summary conclusion, the case notes and the documents gathered during the course of investigation (Justice Center Exhibits 1-25).

The Justice Center investigator testified and did so credibly. The Subject testified on her own behalf and was credible in her testimony. The Subject called [REDACTED], *Director of Residential Services* for [REDACTED] as a witness at the hearing. [REDACTED] testified credibly as well.

During the course of the investigation the Justice Center investigator interviewed [REDACTED]. Although [REDACTED] speech is somewhat compromised, the recording of the interview revealed that [REDACTED] is not significantly intellectually compromised and clearly understood the

questions that were posed to her. Her answers during the interview were often very detailed. [REDACTED] told the investigators that she often fell from bed because she was reaching for “snacks” which she had stowed- bed side. Other times the snacks were on the floor. In any event, [REDACTED] was reaching when she fell.

[REDACTED] acknowledged that she generally didn’t ask staff for help with obtaining the snacks and that her falls or rolls from bed, ceased after the anti-roll mattress was installed. It should also be noted that by the time of the report to the VPCR, [REDACTED] ability to leave the residence to buy “snacks” had greatly diminished, in part because of declining health and in part because more stringent restrictions were placed on [REDACTED]. [REDACTED] denied any injuries as result of the falls.⁷ (Justice Center Exhibit 25: recorded interview with [REDACTED]-service recipient, recorded interview with [REDACTED]-Site Manager and Justice Center Exhibit 6, generally)

At the onset of the falls in [REDACTED] it was unclear whether [REDACTED] was falling while attempting to stand-up from bed, or if [REDACTED] was falling and, or rolling out of her bed. [REDACTED] initially told staff that she had an issue with leg weakness and given her diagnosis of diabetes and her increasing reliance on a wheelchair, the falling appeared medical in origin and not behavioral. However, [REDACTED] initially refused a neurological consult, as was her right. The Justice Center argued that someone should have done something immediately to mitigate the situation. Indeed a floor mat could have been introduced sooner, but as the proof established, even as late as [REDACTED], the floor mat was not well received by [REDACTED] administration and the administration promoted an anti-roll mattress. [REDACTED] was initially resistant to the mattress and even as of the time of the investigation, the *Site Manager* opined in an interview with the Justice Center investigator that [REDACTED] could have refused the mattress, or demanded its removal after

⁷ See Footnote 2.

installation.⁸

After the falls began in [REDACTED], [REDACTED] implemented new safety protocols in an attempt to minimize the falls. After [REDACTED] disclosed that she was falling as she reached for items like food and the remote, [REDACTED] was instructed to call staff for assistance in retrieving items while she was in bed. However, [REDACTED], by her own admission, did not call staff for assistance. [REDACTED] bed checks were increased to once every 15 minutes and the bed was relocated so that two sides of the bed bordered a wall.

There is little question that there was a poor, if not a complete lack of understanding of the process for submitting “rights restrictions” to *the committee*. Additionally, there was no clear consensus within the [REDACTED] as to whether or not bed rails were permitted under any circumstances, at any time.

The entirety of this situation was greatly complicated by the fact that this service recipient was deemed qualified to make her own medical decisions. In fact, [REDACTED] was generally independent enough to venture out into the community unaccompanied. [REDACTED] health and functioning did decline during the spring of [REDACTED] and ultimately more supervision was required of her “outings” by the summer of [REDACTED]. Also in the back drop was significant non-compliance with hygiene on [REDACTED] part. This resulted in multiple skin infections, which were exasperated by her diabetes. During the spring of [REDACTED] may have been seen by physicians as many as three times per week for skin related issues exacerbated by her diabetes and her resistance to hygiene. During this time period, [REDACTED] was for all intents and proposes, still deemed capable of managing her own health care.

⁸ Whether or not this is a correct characterization of the law is not to be resolved by this hearing. However, this interpretation illustrates the systemic confusion regarding consent, rights restrictions and process among key staff at this facility.

With regard to the Subject there was no convincing evidence that she failed any obligation imposed upon her by virtue of her job as a *Behavioral Clinician*. The Subject was not on site at the [REDACTED] on a daily basis. The Subject was responsible for [REDACTED] and approximately 94-96 service recipients. The evidence produced at the hearing established that the Subject's role on *the team*, and in the care review process was to make recommendations on the proposed "rights restriction," to *the committee*. However, per policy of [REDACTED] and OPWDD regulations,⁹ bed rails were intensely discouraged.

While neither the anti-roll mattress nor the floor mat were deemed right's restrictions, (Justice Center Exhibit 25: recorded interview with [REDACTED] - Director of Clinical Services for [REDACTED] the Subject was essentially in a holding pattern while the less restrictive methods were pressed into service. The Subject was largely at the mercy of *the committee*, which was never formally assembled. *The committee* was required to provide the Subject with the physician's script for bedrails, physician notes, nurse bed safety check list,¹⁰ bedrail purchase request, and further to evaluate the possibility of other less restrictive means, including utilizing a [REDACTED] prescribed checklist in. Additionally, there was no job description or similar evidence regarding [REDACTED] duties tendered by the Justice Center. [REDACTED] internal policy placed the obligation on the [REDACTED] *Quality Assurance Coordinator* (CQI), to "verif[y] that the necessary safeguards have been put into place for the individual." (Justice Center Exhibit 8) [REDACTED] internal policy entitled: *Bed Assessment and Bed Safety* dictates that a *Risk Profile Checklist* is to be completed whenever an "individual's condition has changed." This policy outlines specific obligations for the *Site Manager*, [REDACTED] and the *CQI coordinator*. The policy squarely places the obligation on the facility *Registered Nurse* to "consider and recommend [...] the least restrictive bed set up

⁹ See 14 N.Y.C.R.R. Section 633.16 generally.

¹⁰ See Footnote 5.

for the person[,] other than handrails whenever possible...” However, this written policy does not contemplate any action by, or dictate any role of the *Behavioral Clinician* in the process of bed safety recommendations, or modifications. (Justice Center Exhibit 8)

The [REDACTED] executive director testified at the hearing that the Subject, in her capacity as a *Behavioral Clinician*, could have, on an emergent basis, requested that CQI approve the installation of bedrails. However, the evidence clearly established that even an emergency request first required that *the committee* provide the Subject with a script for bedrails, physician notes, nurse bed safety check list, bedrail purchase request, and a [REDACTED] prescribed checklist. Members of *the committee* did not provide this documentation to the Subject; in fact; *the committee* was never assembled and never had a formal meeting.

Additionally, the record is clear, there was no consensus at [REDACTED] as to whether bedrails would be approved on an emergent basis without clear evidence that the falls were due to a medical issue. At no time did any evidence that the falls were related to a medical condition surface in the record. The Subject testified credibly that never in 12.5 years of employment with [REDACTED] had she been aware of bedrails being approved and placed into service, at any [REDACTED] facility.

At the conclusion of the investigation, the Justice Center investigator wrote: “[f]rom a systemic standpoint, [REDACTED] should be charged with a category 4.” (Justice Center Exhibit 4) In the opinion of the Administrative Law Judge presiding over the hearing, there was a systemic failure of understanding and a failure of consistent policy and leadership regarding the interplay between rights restrictions, service recipient consent, and service recipient safety within [REDACTED]. Indeed had this been a Category four allegation, there would have been an overwhelming basis to have affirmed the Substantiation.

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

DECISION:

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

This decision is recommended by Gerard D. Serlin, Administrative Hearings Bureau.

DATED: October 16, 2014
Schenectady, New York


Gerard D. Serlin, ALJ