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 Numbers: [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]

[redacted]

[redacted]

By: Drew Blanton, Esq.
SIU Local 200
1150 University Avenue, Bldg. 5
Rochester, New York 14607

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

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

The substantiated report is properly categorized, or should be categorized as Category 3 neglect.

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

NOW THEREFORE IT IS DETERMINED that the record of this report

as it pertains to [redacted] shall be retained by the Vulnerable Person's Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

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

DATED: Schenectady, New York
January 20, 2015

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjudication Case
[redacted]

Before: Gerard D. Serlin
Administrative Law Judge

Held at: West Seneca DDSO
1200 East and West Road
Building 16
West Seneca, New York 14224
On: [redacted]
Closing arguments submitted [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]

[redacted]

[redacted]

By: Drew Blanton, Esq.
SIU Local 200
1150 University Avenue, Bldg. 5
Rochester, New York 14607

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subjects) for abuse and/or neglect. The Subjects requested that the VPCR amend the report to reflect that the Subjects are not the subjects 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 abuse and/or neglect of a Service Recipient by the Subjects.

2. Commencing on [redacted] and continuing until [redacted] mandated reporters called the VPCR to report that the Service Recipient was being wrapped in sheets and blankets at bedtime, in order to ensure that she remained in bed. (Justice Center Exhibit 10)

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

4. On or about [redacted] the Justice Center substantiated the report against the Subject [redacted] based upon the conclusion that he failed to report a reportable incident. The Justice Center concluded that:

> … [O]n the morning of [redacted] at the [redacted], located at [redacted], while acting as a custodian, [Subject [redacted]] observed a service recipient immobilized in her bedding in an improper restraint, and [Subject [redacted]] failed to report this [to the VPCR]. (Justice Center Exhibit 1)

5. On or about [redacted] the Justice Center substantiated the report against the Subject [redacted] based upon the conclusion that he failed to report, a reportable incident. The Justice Center concluded that:

> ...[O]n dates prior to [redacted], at the [redacted], located at [redacted] while acting as a custodian, you became aware that a service recipient was immobilized in her bedding in an improper restraint, and you failed to report this act of abuse or neglect, thereby impeding the discovery of the use of this improper method of restraint. (Justice Center Exhibit 2)

6. On or about [redacted] the Justice Center substantiated the report against the Subject [redacted] based upon the conclusion that he failed to report, a reportable incident. The Justice Center concluded that:

> … [O]n the morning of [redacted], at the [redacted], located at [redacted], while acting as custodian, you observed a service recipient immobilized in her bedding in an improper restraint and you failed to report this act of abuse or neglect, thereby impeding the discovery of the use of this improper method of restraint. (Justice Center Exhibit 3)

7. With all three Subjects the Category assessed was a Category 3.

8. An Administrative Review was conducted and as a result the substantiated reports were retained.

9. At the time of the report, the three Subjects were employed by [redacted] at the [redacted] located at [redacted] The Subjects were employed as direct care staff by a facility or provider agency that is subject to the jurisdiction of the Justice Center. The Subjects are mandated reporters of abuse and/or neglect.

10. The Service Recipient was 50 years of age at the time of the report and had been a resident of the [redacted] since 1986. The Service Recipient is a person with a diagnosis of

epilepsy, mild developmental disabilities and severe bipolar disorder. The Service Recipient was unable to assist investigators during the course of this investigation. The [redacted] provides 24 hour, high level supervision residential care to special needs residents. Ten residents resided at the [redacted], at the time of the report.

11. All three Subjects had been employed at the [redacted] for some time, and were current in their Strategies for Crisis Intervention and Prevention training (SCIP training). Additionally, in [redacted], all three Subjects completed training with regard to the Justice Center, which included a component in mandated reporter reporting requirements.

12. On or about [redacted], new staff members at the [redacted] were undergoing SCIP training. None of the new staff who participated in the training are the Subjects of this substantiated report. During the course of the SCIP training, in a classroom discussion, a new [redacted] staff person disclosed that they had witnessed the Service Recipient being "wrapped like a taco" in her sheets and blankets during the overnight hours at the [redacted].

13. The Service Recipient experienced periods of extreme mania. During those periods the Service Recipient was: very active, often awake for days at a time and required one-on-one supervision by staff. (Testimony as contained in the Hearing record). The Service Recipient's "weighted blanket plan" specified the use of a weighted blanket to be used as a calming tool, periodically throughout the day at 20 minute intervals. The weighted blanket was never to be used a restraint. The weighted blanket was prescribed to be used for the Service Recipient when she was in a manic phase associated with her bi-polar disorder. (Justice Center Exhibit 27)

14. The Service Recipient could refuse the use of the weighted blanket. This weighted blanket was never used while the Service Recipient was sleeping. (Justice Center Exhibit 19: recorded interview with Subject [redacted])

15. At the time of the Justice Center investigation, the weighted blanket had no weights in it, and it did not appear to be in-service. (Hearing testimony of Justice Center investigator [redacted], Justice Center Exhibits 17 & 18)

16. Some staff members at the [redacted] were wrapping the Service Recipient tightly in sheets during the overnight. In some instances staff wrapped the Service Recipient while the Service Recipient was in a standing position. As the Service Recipient stood, staff members walked around the Service Recipient wrapping a sheet and/or blanket around her. The Service Recipient would be wrapped up to her shoulders. The Service Recipient's arms and hands would be immobilized in the wrap. The Service Recipient was then placed down on to her bed for the evening. Wrapping the Service Recipient hindered and likely impeded the Service Recipient's ability to extricate herself from bed or to move freely.

17. [redacted] worked at the [redacted] 5 days per week, Monday through Friday 6 a.m. to 10:00 a.m. Most of [redacted] interactions with the Service Recipient were during the morning. During her manic phases, the Service Recipient typically required one-on-one supervision. The Service Recipient was generally capable of getting herself up in the morning. [redacted] had worked with the Service Recipient for about 4 years before this investigation began. From time to time the Service Recipient wrapped herself in sheets as she slept. The Service Recipient had also become tangled in sheets from time-to-time. (Testimony of Justice Investigator Center [redacted])

18. On the morning of [redacted], [redacted] discovered the Service Recipient wrapped in sheets in a "cocoon." While [redacted] had seen the Service Recipient wrapped or tangled in her sheets before, never had [redacted] seen the Service Recipient wrapped in a "cocoon." The Service Recipient's arms were wrapped inside the sheet. The sheet did not go above her neck. The Service Recipient was capable of getting herself unwrapped but it was a bit of a struggle. It took the Service Recipient about 20 seconds to extricate herself from the sheets. [redacted] concluded that this wrapping may have been intentional, but if so-was done to comfort the Service Recipient; [redacted] also concluded that the "wrapping" which he observed was equivalent to a restraint and that when the Service Recipient was wrapped in this fashion, her ability to quickly extricate herself from bed was impeded.

19. Subject [redacted] walked by the Service Recipient's room at this time and stood at the doorway. [redacted] said to Subject [redacted] either: "who would have done this?" or, "how did this happen?" [redacted] said that he "didn't know."

20. Subject [redacted] testimony, unrebutted in the record, was that he first knew of the "wrapping" of the Service Recipient after the Justice Center commenced its investigation. Subject [redacted] testified that on one occasion he was assigned to watch the Service Recipient for 12 hours when no one else would watch her since she had scabies, he had yelled down the hall for help in putting the Service Recipient to bed.

ISSUES

- Whether the Subjects have 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 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 or neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of 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 Subjects have 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 of abuse or neglect that such act or acts constitute.

The abuse and 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 obligations of a mandated reporter are set forth in Social Services Law § 491:

> Duty to report incidents. 1. (a) Mandated reporters shall report allegations of reportable incidents to the vulnerable persons' central register as established by section four hundred ninety-two of this article and in accordance with the requirements set forth therein.
>
> (b) Allegations of reportable incidents shall be reported immediately to the vulnerable persons' central register upon discovery. For purposes of this article, "discovery" occurs when the mandated reporter witnesses a suspected reportable incident or when another person, including the vulnerable person, comes before the mandated reporter in the mandated reporter's professional or official capacity and provides the mandated reporter with reasonable cause to suspect that the vulnerable person has been subjected to a reportable incident. A report to the register shall include the name, title and contact information of every person known to the mandated reporter to have the same information as the mandated reporter concerning the reportable incident. Nothing in this subdivision shall be construed to prohibit a mandated reporter from contacting or reporting to law enforcement or emergency services before or after reporting to the vulnerable persons' central register.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the subjects 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 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 neglect and/or 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 of abuse set forth in the substantiated report.

If the Justice Center did not prove the neglect and/or 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 the Subject [redacted] committed the neglect alleged in the substantiated report. The category of neglect that such act or acts constitute is a Category 3.

The Justice Center ***has not*** established by a preponderance of evidence that the Subject [redacted] committed the neglect alleged in the substantiated report.

The Justice Center ***has not*** established by a preponderance of evidence that the Subject [redacted] committed the neglect alleged in the substantiated report.

In support of its indicated findings, the Justice Center presented Justice Center Exhibits 1-27. Three witnesses also testified on behalf of the Justice Center. The Subjects testified on their own behalf.

[redacted] *Justice Center interview:* (Justice Center Exhibit 19)

On [redacted] was interviewed by an investigator with the Justice Center. [redacted] job title was *direct support professional*. [redacted] told the investigator that the first time that he became aware of the allegations involving the Service Recipient was after the Justice Center investigation began and after a local newspaper article appeared about the

"wrapping." When asked if he had ever seen the Service Recipient wrapped in her sheets, [redacted] replied that he had, but that she was able to free herself.

[redacted] then described discovering the Service Recipient wrapped in a "cocoon" one morning. The Service Recipient's arms were wrapped inside the sheet. The sheet did not go above her neck. [redacted] stated that staff member [redacted], also a Subject, walked by the room and peaked into the room. [redacted] said to Subject [redacted] "who would have done this?" or "how did this happen?" [redacted] said that he "didn't know." [redacted] stated that the Service Recipient was able to extricate herself from the sheet without assistance.

[redacted] stated that this was the first and only time he had seen the Service Recipient wrapped like this. [redacted] also stated during the interview that he believed that someone had wrapped the Service Recipient in the sheet. [redacted] stated that if he had seen the Service Recipient wrapped like this at any other time, that he would have reported this to his supervisor.

The Justice Center investigator asked [redacted] to speculate about the reason why staff would have wrapped the Service Recipient in the sheet. [redacted] stated that it may have been to comfort the Service Recipient but he also acknowledged when questioned, that the wrapping which he observed was equivalent to a restraint and could have impeded the Service Recipient from quickly extricating herself from bed, had there been an emergency. [redacted] stated that he did not inquire as to how the Service Recipient's behavior and demeanor were in the overnight. [redacted] was not asked during the interview if the Service Recipient was in a manic phase during this time period.

When asked to provide a date when he made this discovery, [redacted] stated that he did not work on the weekends and therefore this must have been a weekday. During the interview the investigator provided [redacted] with log sheets from the relevant time period. After a review of

relevant records, [redacted] concluded that he made this discovery on the morning of [redacted]

[redacted] *hearing testimony*

At the hearing [redacted] testified that he worked at the [redacted] 5 days per week, Monday through Friday [redacted]. Most of this Subject's interactions with the Service Recipient were in the morning. During her manic phases, the Service Recipient typically required one-on-one supervision. The Service Recipient was generally capable of getting herself up in the morning. [redacted] worked with the Service Recipient for about 4 years.

[redacted] testified that the first time that he heard of the Service Recipient being wrapped by staff was after the commencement of the Justice Center investigation. [redacted] testified that he had discovered the Service Recipient wrapped in sheets and blankets a number of times, but that he had attributed this to the Service Recipient's own doing, as the Service Recipient often did wrap and tangle herself during the overnight. [redacted] testified that one morning (presumably the [redacted]), he briefly thought that the Service Recipient could have been intentionally wrapped by staff, but that he was not sure and, in any event, the Service Recipient was capable of unwrapping herself. [redacted] testified that he witnessed the Service Recipient freeing herself from the sheets; it was a little bit of a struggle and it took the Service Recipient "about 20 seconds" to extricate herself.

However, after a couple of minutes of reflection, he concluded that the wrapping was not done intentionally. [redacted] also testified that, at the time of this discovery, he concluded that "he wasn't sure", whether or not the Service Recipient had been intentionally wrapped.

On that morning, staff [redacted] asked [redacted] if he needed help getting the Service Recipient ready. There was some conversation and [redacted] said to [redacted] "who

could have done this?" but to that [redacted] did not respond. [redacted] was uncertain if [redacted] heard everything [redacted] told him.

[redacted] also testified that when the Service Recipient wrapped herself in a blanket or a sheet, she typically crossed her own arms across her chest. [redacted] acknowledged on cross-examination that during his interview with the Justice Center investigator on [redacted], he provided little information about the Service Recipient's "self-wrapping behaviors" but that in his direct hearing testimony, he provided many more vivid details about the Service Recipient's "self-wrapping behaviors."

[redacted] *testimony*

At the hearing [redacted] testified that he worked at the [redacted] 5 days per week, and that he worked random shifts: overnights, days, mornings and nights. [redacted] typically worked 40-70 hours per week. [redacted] denied any conversation with [redacted] on the morning of [redacted]. He testified that he had learned of this practice of wrapping the Service Recipient from a newspaper article. [redacted] never saw the Service Recipient wrapped tightly, but did see the Service Recipient wrapped up loosely several times and believed that the Service Recipient had done this to herself. [redacted] claimed no previous knowledge of "Burrito wrapping." [redacted] was often the Service Recipient's one-on-one aid-when she was highly manic. When the Service Recipient needed one-on-one supervision, staff was rotated every hour because the Service Recipient required so much attention.

[redacted] *Justice Center interview:* (Justice Center Exhibit 19)

During the course of the investigation Subject [redacted] was interviewed twice by investigators with the Justice Center. The initial interview with [redacted] occurred on or about early

[redacted] and was conducted by one Justice Center investigator. That interview was not recorded.

Thereafter, on or about [redacted], [redacted] was re-interviewed, this time by two Justice Center investigators. This re-interview did result in an audio recording. (Justice Center Exhibit 19) During the re-interview [redacted] initially denied knowing anything about the Service Recipient being "wrapped up." [redacted] stated that he had been away from the [redacted] for a time and had returned to the [redacted] sometime in late [redacted] or early [redacted]. [redacted] denied ever asking for assistance from other staff with wrapping the Service Recipient

[redacted] recalled a day when the Service Recipient was diagnosed with scabies and none of the other staff members would "touch" the Service Recipient. However, [redacted] was assigned to watch the Service Recipient for 12 hours in order to minimize the number of staff members exposed to the Service Recipient. After 12 hours of supervising the Service Recipient, [redacted] yelled down the hall that he needed someone to help him put the Service Recipient to bed so that he could complete his paperwork. Staff [redacted] appeared and offered his assistance. [redacted] stated staff [redacted] emerged from the Service Recipient's room about 20 minutes later, and [redacted] stated that the Service Recipient was sleeping.

[redacted] denied that he had ever asked staff [redacted] for assistance in wrapping the Service Recipient. [redacted] denied any knowledge of [redacted] wrapping the Service Recipient and stated that [redacted] worked days and that he worked overnights. [redacted] claimed that the Service Recipient had not been highly manic in several months.

Finally after intense interrogation, [redacted] admitted that he had heard [redacted] was wrapping the Service Recipient and that staff [redacted] "may have been" wrapping the Service Recipient. [redacted] also acknowledged that staff [redacted] had given him a "hard time" because she

thought it was he, who had "turned her in" for wrapping the Service Recipient. [redacted] stated that staff [redacted] told him that staff [redacted] had been wrapping the Service Recipient. [redacted] acknowledged that he heard [redacted] had wrapped the Service Recipient tightly like a "Burrito." However, he had never seen this and had only worked the overnight with [redacted], once or possibly twice. At no time during the interview did [redacted] clarify when he first "heard" of staff wrapping the Service Recipient and clarification was not sought by the investigators.

[redacted] stated that bed checks of female service recipients were typically conducted by female staff; because of this practice, [redacted] claimed that he rarely saw the Service Recipient in bed. Additionally, [redacted] stated that while he did work the evening shift, his shift was relieved by the later midnight shift. [redacted] stated that the midnight shift was highly successful at getting the Service Recipient to go to sleep.

[redacted] *hearing testimony*

[redacted] testified that he had always worked at the [redacted], except for a time in [redacted] when he was away, and then retuned sometime between late [redacted] and [redacted]. [redacted] testified that he had no knowledge before the commencement of the Justice Center investigation of the wrapping and claimed that staff [redacted] told him that [redacted] was under investigation for wrapping the Service Recipient. [redacted] testified that [redacted] may have been a staff member who was "wrapping" the Service Recipient but that any one of the staff could have assisted him,[1] on the evening of his 12 hour supervision of the Service Recipient[2]

[1] In his interview with the Justice Center, [redacted] denied ever having been instructed on how to wrap Service Recipient [redacted] also denied that he was the staff member who responded to "[redacted]" call for assistance in putting Service Recipient to bed, after [redacted] 12 hour supervision of Service Recipient [redacted] told investigators that it was [redacted] who assisted [redacted] with putting Service Recipient to bed.

[2] Though implied in the record, there was no evidence in the record that any staff actually wrapped Service Recipient in a "cocoon" or like a "Burrito" during the overnight following [redacted] 12 hour supervision of Service Recipient

Interview with [redacted]: (Justice Center Exhibit 19)

UCP training coordinator [redacted] told the investigator that staff [redacted] identified another resident's staff advocate, as someone who had shown her how to wrap the Service Recipient tightly at night and that [redacted] observed the staff member wrap the Service Recipient one evening. [redacted] reported that the following morning the Service Recipient was still wrapped and was also soiled in urine and feces. After further investigation, [redacted] identified the staff as [redacted]

Interview with staff [redacted]: (Justice Center Exhibit 19)

During the course of the investigation staff [redacted] was interviewed twice by investigators with the Justice Center. In both interviews [redacted] expressed concern about her job security and made allegations of a culture of retribution at work because she had disclosed the wrapping during SCIP training. The first interview occurred on or about [redacted] and was conducted by one Justice Center investigator. This interview was recorded with the use of audio recording equipment. Thereafter, on or about [redacted] was re-interviewed, this time by two Justice Center investigators. That re-interview was also preserved in an audio recording. (Justice Center Exhibit 19)

Interview # 1 [redacted]: (Justice Center 19)

[redacted] stated during the interview of [redacted] that she was a "floater" with no assigned shift. [redacted] began working at the [redacted] in late [redacted]. [redacted] reported that during her SCIP training, in late [redacted] she learned that wrapping service recipients is a form of abuse. [redacted] stated that she had heard staff talking about wrapping the Service Recipient and she had seen the Service Recipient wrapped in the morning. [redacted] stated that she had never seen the Service Recipient being wrapped but claimed that an employee

volunteered to help put the Service Recipient to bed because she [redacted], was having a difficult time getting the Service Recipient to bed. However, [redacted] did not know the name of the employee whom had volunteered to put the Service Recipient to bed. [redacted] stated that she did not know if the Service Recipient was wrapped by any employee that evening.

[redacted] stated that, on another date and during the morning time, she discovered the Service Recipient wrapped in a sheet and standing up. [redacted] asked for help unwrapping the Service Recipient but did not recall the date when she observed this. At the time of the interview, the only relevant staff names which [redacted] could recall were the names of employees who were no longer employed by the [redacted]. [redacted] was only able to recall the name of one co-worker with whom she was working with on the shift when she was interviewed on [redacted].[3]

Interview # 2 [redacted]*:* (Justice Center 19)

[redacted] stated during the interview of [redacted] that she had heard that wrapping the Service Recipient was a practice at the [redacted], but could not recall the name or names of the staff that she worked with at the [redacted], who had told her of this practice. During this interview [redacted] was also shown photographs of employees and asked to identify employees with whom she had worked. [redacted] was asked to identify photos of employees who were working on the day when she heard that it was common for the Service Recipient to be "wrapped up." Eventually, from a photograph [redacted] identified a staff member who [redacted] was told, was wrapping the Service Recipient. The staff member who [redacted] identified was a female staff member.

Interview with staff [redacted]*:* (Justice Center Exhibit 19)

[3] The investigator appeared to be "testing" [redacted] continued assertion that she rarely recalled the names of anyone- expect immediate family members.

During the course of the investigation, [redacted] staff [redacted] was interviewed twice by Justice Center investigators. The first interview occurred on or about [redacted], and was conducted by one Justice Center investigator. This interview was recorded with the use of audio equipment. Thereafter, on or about [redacted] was re-interviewed, this time by two Justice Center investigators. The re-interview of [redacted] was also recoded with audio recording equipment. (Justice Center Exhibit 19)

Interview # 1 [redacted]*:* (Justice Center Exhibit 29)

At the time of the interview [redacted] had been employed at the [redacted] for about 4 weeks. [redacted] claimed that he had only put the Service Recipient to bed twice in his time at the [redacted] [redacted] stated that he once heard "[redacted]" say that "[redacted] does it the best", meaning [redacted] wraps the Service Recipient the best. One night he heard "[redacted]" say "who can help?" and "[redacted]" also said: "someone help me put the Service Recipient to bed." About an hour later [redacted] went to the Service Recipient's room to help him put the Service Recipient to bed.

[redacted] also acknowledged that staff members had told him to wrap the Service Recipient. He indicated that [redacted] and "[redacted]" knew how to wrap the Service Recipient and had told him to do it, but no one had ever shown him how to wrap the Service Recipient. [redacted] also stated that "[redacted]" was "running through house" one night asking for someone to do something to the Service Recipient, possibly "wrap her" but [redacted] also stated that maybe [redacted] just "asked for help" in putting the Service Recipient to bed.

Interview # 2 [redacted]*:* (Justice Center 29)

During the interview of [redacted], [redacted] stated again that he heard [redacted] did it the best. However, [redacted] could not recall who told him this. [redacted] claimed that he

never saw [redacted] or anyone else wrap the Service Recipient. [redacted] stated that on the night at issue, "[redacted]" definitely said: "Can someone help me put the Service Recipient to bed?" But [redacted] wasn't certain that "[redacted]" didn't say, at some point, "can someone please come and wrap the Service Recipient?" [redacted] also stated that, *after the investigation began,* "[redacted]" and other staff stated that they did not understand why the wrapping was an issue, because, "it works." [redacted] identified four other employees who stated that wrapping the Service Recipient "works." None of the staff identified included the Subjects, except [redacted]. [4] The only Subject who was identified as having wrapped the Service Recipient was [redacted].

[redacted] also stated that a morning staff person had told him that the most effective way to get the Service Recipient to sleep was to wrap her with a blanket or sheet while she stood up. [redacted] explained that as he understood it, the Service Recipient would be wrapped as many as two times, meaning the wrapper would walk twice around the Service Recipient and then lay the Service Recipient down on the bed.

Interview with [redacted]*:* (Justice Center Exhibit 19)

On [redacted], an [redacted] staff member, was interviewed by a Justice Center investigator. [redacted] was then a part time employee who worked sporadic shifts beginning on or about [redacted].

[redacted] told the investigator that, about two or possibly two and one-half weeks before the Justice Center interview, she had discovered the Service Recipient in the morning "wrapped like

[4] Throughout his interview [redacted] referred to "[redacted]" but never said [redacted] or [redacted] in his interview. In her notes the investigator wrote: "He [[redacted] stated that [redacted], … told him it works." (Justice Center Exhibit 10, page 2 paragraph 1) At the hearing [redacted] did not raise this issue and as it is discussed later, [redacted] testified that he did not become aware of the wrapping until after the investigation began. It is presumed that [redacted] was referring to [redacted] in his interview with the Justice Center investigators when he referred to "[redacted]." (Justice Center Exhibit 19)

a taco" in both a blue sheet and a "teddy bear blanket." [5] [redacted] then asked staff [redacted] if this was "right?" and she said, "Yeah, sometimes they put her to bed like that." When pressed for an exact date [redacted] could not provide same, and [redacted] was not clear as to how she concluded that this had occurred two weeks before.

Analysis [redacted]

In [redacted] hearing testimony, he denied any conversation with [redacted] on the morning of [redacted], as well as at any other time pertaining to wrapping the Service Recipient He stated that he had learned of the practice of wrapping the Service Recipient from a newspaper article published after the Justice Center began its investigation. [redacted] testified that he never saw the Service Recipient wrapped tightly, but did see the Service Recipient wrapped up loosely several times and believed that the Service Recipient had done this to herself. [redacted] claimed no previous knowledge of "Burrito" wrapping of the Service Recipient. [redacted] testimony was marginally credible.

The only evidence in the record to support the conclusion that [redacted] may have had *Reasonable Cause* that a reportable incident occurred is the hearsay statement of Co-Subject [redacted], in which he told the investigator(s) that [redacted] walked by the Service Recipient's room on [redacted], peeked into the room and observed that the Service Recipient was wrapped in a "cocoon." [redacted] claimed that he said to Subject [redacted] "how did this happen?" [redacted] claimed that [redacted] said that he "didn't know." [redacted] effectively recanted this assertion in his hearing testimony and stated that [redacted] did not respond to his

[5] The "teddy bear" blanket was closest to [redacted] skin. This was not a full sized blanket and was wrapped over [redacted] arms. The sheet was wrapped on top of the blanket and was tucked in at chest level "like a towel."

inquiry. [redacted] testified that he was uncertain if [redacted] heard everything that [redacted] had told him.

Assuming that the conversation between [redacted] and [redacted] went as [redacted] described in his interview with the Justice Center, evidence of this conversation alone, without more is not enough to establish by a preponderance of the evidence that [redacted] had *Reasonable Cause* to suspect that a reportable incident occurred. [redacted] original statement on the issue of what he said to [redacted] is very limited. There was nothing in [redacted] oral statement to indicate whether the Service Recipient was standing up or lying in bed when observed by [redacted] During [redacted] interview with the Justice Center, [redacted] indicated that [redacted] stood in the doorway. The fact that [redacted] may have said to [redacted] either: "who would have done this?" or "how did this happen?" and that [redacted] may have said that he "didn't know," does not establish by a preponderance that [redacted] had *Reasonable Cause* to suspect that a reportable incident had occurred.

Analysis [redacted]

[redacted] acknowledged during his second interview with the Justice Center that he "heard" that [redacted] was wrapping the Service Recipient tightly like a "Burrito" and that staff [redacted] "may have been" wrapping the Service Recipient. However, [redacted] stated that he had never seen the Service Recipient being wrapped and that he had only worked the overnight with [redacted], once or possibly twice. *At no time during the interview did* [redacted] *clarify when he first "heard" of staff wrapping the Service Recipient and clarification was not sought by the investigators. Had such clarification appeared in the audio interview, the outcome of this case as it pertains to* [redacted] *may have been different.*

In his marginally credible hearing testimony, [redacted] stated that he first heard of the practice of wrapping the Service Recipient after the Justice Center investigation commenced and that this was the time period to which he was referring, when he was interviewed. [redacted] hearing testimony is the only evidence in the record specifying the time period when [redacted] first heard of the wrapping.

The entirety of the remaining evidence pertaining to [redacted] is hearsay evidence. Hearsay is admissible in administrative proceedings and an administrative determination may be based solely upon hearsay evidence under appropriate circumstances *Gray v. Adduci*, 73 N.Y.2d 741 (1988), *300 Gramatan Avenue Associates v. State Division of Human Rights*, 45 N.Y.2d 176 (1978), *Eagle v. Patterson*, 57 N.Y.2d 831 (1982), *People ex rel Vega v. Smith*, 66 N.Y.2d 130 (1985). A crucial concern with respect to hearsay evidence is the inability to cross- examine the person who originally made the statement in order to evaluate his or her credibility. Such evidence, then, must be carefully scrutinized and weight attributed to it would depend upon its degree of apparent reliability. Factors to be considered in evaluating the reliability of hearsay include the circumstances under which the statements were initially made, information bearing upon the credibility of the person who made the statement and his or her motive to fabricate, and the consistency and degree of inherent believability of the statements.

The mainstay of the hearsay evidence is the interview statements of [redacted] (Justice Center Exhibit 19) [redacted] stated that he once heard "[redacted]" say that, "[redacted] does it the best," meaning [redacted] wraps the Service Recipient the best. [redacted] also claimed that one night he heard "[redacted]" say, "who can help?" and that "[redacted]" also said "someone help me put the Service Recipient to bed." About an hour later [redacted] went to the Service Recipient's room to help him put the Service Recipient to bed. However, there was no indication that the

Service Recipient was wrapped that evening.

He also indicated that [redacted] and "[redacted]" knew how to wrap the Service Recipient and had told him to do it. [redacted] also stated that "[redacted]" was "running through house" one night asking for someone to do something to the Service Recipient, possibly "wrap her" but [redacted] also stated that maybe [redacted] just "asked for help" in putting the Service Recipient to bed. [redacted] statements were equivocal. In his subsequent interview, [redacted] was equally ambiguous and stated that: "[redacted]" "definitely" said "can someone help me put the Service Recipient to bed," but [redacted] wasn't certain that "[redacted]" didn't say, at some point, "can someone please come and wrap the Service Recipient"

Additionally, there is no question that [redacted] had been identified by some staff member as a person who was instructed on how to wrap the Service Recipient and as a staff member who had wrapped the Service Recipient. [redacted] was identified by [redacted] as the person who assisted him in putting the Service Recipient to bed, after [redacted] 12 hour one-on-one shift with the Service Recipient. [redacted] denied all of those allegations and stated that he was not the person who had assisted [redacted] in getting the Service Recipient to bed.

At the time of his interview, [redacted] was a potential target of the investigation and was amply aware of this fact. He had sufficient motive to fabricate. Additionally, the Justice Center investigator concluded that [redacted] was inconsistent with the information which he provided in his interview with the Justice Center versus the information which he disclosed to UCP trainer, [redacted]. (Justice Center Exhibit 10, page 3) Based upon the foregoing, the hearsay statements of [redacted] are not credited evidence on any material fact relative to [redacted]

Analysis [redacted]

The obligations of a mandated reporter are set forth in Social Services Law § 491:

> Duty to report incidents. 1. (a) Mandated reporters shall report allegations of reportable incidents to the vulnerable persons' central register as established by section four hundred ninety-two of this article and in accordance with the requirements set forth therein.
>
> (b) Allegations of reportable incidents shall be reported immediately to the vulnerable persons' central register upon discovery. For purposes of this article, "discovery" occurs when the mandated reporter witnesses a suspected reportable incident or when another person, including the vulnerable person, comes before the mandated reporter in the mandated reporter's professional or official capacity and provides the mandated reporter with ***reasonable cause*** to suspect that the vulnerable person has been subjected to a reportable incident.

Reasonable cause is not defined in the relevant enabling legislation. Nor is reasonable cause defined in any rule or regulation promulgated by the Justice Center. The Justice Center does however define reasonable cause on its web site:[6]

> Reasonable Cause means that, based on your observations, training and experience, you have a suspicion that a vulnerable person has been subject to abuse or neglect as described below. Significant incidents that may place a vulnerable person at risk of harm must also be reported. Reasonable cause can be as simple as doubting the explanation given for an injury.

It is a well settled proposition of New York law that an agency's interpretation of the statutes and regulations it is responsible for administering is entitled to great deference. *Kurland v. New York City Campaign Fin. Bd.*, 23 Misc. 3d 567, 873 N.Y.S.2d 440, 2009 NY Slip Op 29027 [N.Y. Sup Ct, New York County 2009] citing *Seittelman v Sabol*, 91 NY2d 618, 625, [1998]; *Matter of Partnership 92 LP & Bldg. Mgt. Co., Inc. v State of N.Y. Div. of Hous. & Community Renewal,* 46 AD3d 425, 429, [1st Dept 2007]; *New York City Campaign Fin. Bd. v Ortiz,* 38 AD3d 75, 80-81, [1st Dept 2006]

[6] See: New York State Justice Center for the Protection of People with Special Needs, N.Y.S. Protection of People with Special Needs Act Notice To Mandated Reporters Justice Center Guidance – June 11, 2013, http://www.justicecenter.ny.gov/sites/default/files/documents/Notice_to_Mandated_Reporters_06-11-2013.pdf

Enforcement of, and interpretation of Social Services Law § 491 requires an "understanding of [the] underlying operational practices" of the facilities and provider agencies which employ persons who are subject to jurisdiction by the Justice Center, and the "question of statutory interpretation is generally left to the special expertise of the agency and the determination is entitled to deference..." *Jennings v. N.Y. State Office of Mental Health,* 90 N.Y.2d 227, [N.Y. 1997], citing *Kurcsics v Merchants Mut. Ins. Co.,* 49 NY2d 451, 459, [1980]

During his interview with the Justice Center on [redacted], [redacted] described discovering the Service Recipient wrapped in a "cocoon" on the morning of [redacted]. The Service Recipient's arms were wrapped inside the sheet. [redacted] said to Subject [redacted] "who would have done this?" or "how did this happen?" [redacted] worked with the Service Recipient for about 4 years previous to this incident and had never seen the Service Recipient wrapped like this.

Even during [redacted] hearing testimony, in which he unconvincingly minimized many of the inculpatory statements he made during the Justice Center interview, [redacted] credibly testified that, at the time of discovery, he had concluded that "he wasn't sure" if the Service Recipient had been intentionally wrapped. The statements [redacted] made to Justice Center investigators taken together with the credited portions of his hearing testimony, clearly establish that based on [redacted] observations, training and experience, [redacted] had a suspicion that the Service Recipient had been subjected to abuse or neglect.

[redacted] acknowledged that the manner in which he observed the Service Recipient to be wrapped was equivalent to a restraint and could have impeded the Service Recipient from quickly extricating herself from bed, had there been an emergency. This is convincing evidence that [redacted] opinion, at the time of discovery, was that the Service Recipient was subjected to a

restraint.[7] The evidence established that this restraint was not warranted under the relevant SCIP training, which was the adopted policy of the Office for the Protection of People with Developmental Disabilities (OPWDD), at the time of the report, and additionally was contrary to the Service Recipient's individual treatment plan, behavioral intervention plan or the functional equivalent thereof and/or other generally accepted treatment practices. (Justice Center Exhibits 25 & 26)

The Justice Center has proven by a preponderance of the evidence that [redacted] was a mandated reporter who had ***reasonable cause*** to suspect that the Service Recipient had been subjected to a reportable incident and [redacted] failed to immediately report this suspicion to the Vulnerable Persons' Central Register.

The conduct as alleged and the substantiation of the report having both been affirmed, the next question to be decided is whether the substantiated allegation constitutes the Category of neglect as set forth in the report. It is determined that the substantiated report is properly categorized as a Category 3 report, and that further, the report should properly be categorized as neglect.

A substantiated Category 3 finding of neglect will not result in [redacted] name being placed on the VPCR Staff Exclusion List and the fact that [redacted] 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.

[7] A restraint is defined as "… 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. " SSL § 488 1 (d)

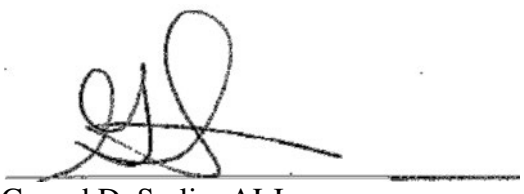
DECISION: The request of [redacted] and [redacted] that the substantiated report [redacted], dated [redacted] be amended and sealed is granted. The Subjects [redacted] and [redacted] have not been shown by a preponderance of the evidence to have committed neglect.

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

The substantiated report is properly categorized, or should be categorized as category 3 neglect.

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

DATED: December 15, 2014
Syracuse, New York



Gerard D. Serlin, ALJ