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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

FINAL DETERMINATION AFTER HEARING

ADJUDICATION CASE
[redacted]

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

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

[redacted]

By: Rodney L. Drake
600 Johnson Avenue
Bohemia, New York 11716

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

ORDERED: The request of [redacted] that the substantiated report [redacted] dated [redacted] be amended and sealed is affirmed with respect to the allegation that she pulled the service recipient by her neck.

The request of [redacted] that the substantiated report [redacted] dated [redacted] be amended and sealed is denied with respect to the allegation that she pushed the service recipient to the floor. The Subject has been shown by a preponderance of the evidence to have committed abuse.

The substantiated report properly determined that the Subject's abuse of the service recipient constituted a Category three finding of abuse.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

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

DATED: Schenectady, New York
January 23, 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: Sharon Golish Blum
Administrative Law Judge

Held at: Adam Clayton Powell Jr. State Office Building
163 W 125th Street
New York, New York 10027
On: [redacted]

Parties: 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: Julianne O'Brien, Esq.

[redacted]
[redacted]
[redacted]
By: Rodney L. Drake
600 Johnson Avenue
Bohemia, New York 11716

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (hereinafter "the VPCR") maintains a report substantiating [redacted] (hereinafter "the Subject") for abuse. 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.

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 physical abuse by the Subject against a Service Recipient.

2. The initial report alleges, in pertinent part, that on or about [redacted], the Subject, [redacted], committed an act of abuse at [redacted], (hereinafter "the facility") by pulling the Service Recipient by the neck and pushing her to the floor. (Subject Exhibit 1)

3. The initial report was made to the Justice Center for the Protection of People with Special Needs (hereinafter "the Justice Center") on [redacted]. The report was investigated by an Office of People with Developmental Disabilities (OPWDD) Internal Investigator.

4. On or about [redacted], the Justice Center substantiated the report against the Subject for abuse. The Justice Center concluded that:

Offense 1

> On [redacted], at [redacted], located at [redacted], while acting as a custodian (LPN), you committed an act of physical abuse when you pulled a service recipient by her neck during an argument and pushed her to the floor.
>
> This offense has been SUBSTANTIATED as Category 3 offense pursuant to Social Services Law § 493.

[redacted]

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

6. The facility, located at [redacted], is operated by the New York State Office for People with Developmental Disabilities (hereinafter "the OPWDD"), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

7. At the time of the alleged abuse the Subject, [redacted], (hereinafter "LPN [redacted]") had been employed at the facility for over seven years and was employed, at the time, as a Licensed Practical Nurse. She qualified as a Registered Nurse in [redacted] and was on orientation/probation at the time of the incident. (Justice Center Exhibit 8)

8. At the time of the alleged abuse, the Service Recipient was 28 years of age and had been a resident of the facility since [redacted], when she had been transferred from [redacted]. The Service Recipient is a person with a diagnosis of bipolar disorder, mild mental retardation and type-1 diabetes. On [redacted], the Service Recipient was a resident of the facility's building [redacted], suite [redacted]. (Justice Center Exhibit 8)

9. LPN [redacted] had normally worked in building [redacted] of the facility and was floated to other suites at times, including on [redacted], when she was floated to building [redacted], suite [redacted].

10. On the morning of [redacted], LPN [redacted] was working with RN [redacted] in an area designated for residents to receive their medications, at the back of building [redacted], suite [redacted]. At approximately 8:30 am, the Service Recipient came to the designated area for her morning medication. The Service Recipient initially appeared to be in a good mood. She was talkative, joking and dancing. (Justice Center Exhibit 8)

11. When the Service Recipient sat down to have her blood pressure checked by LPN

[redacted], before receiving her medication, Service Recipient A ran up to the medication cart near her, grabbed a bottle of hand sanitizer and ran off. RN [redacted] chased after Service Recipient A to retrieve the hand sanitizer, leaving the Service Recipient in the chair having her blood pressure taken by LPN [redacted] (Justice Center Exhibit 19)

12 When RN [redacted] returned to the area a few moments later, the Service Recipient was sitting on the floor, with her back to the wall and her legs straight out in front of her. LPN [redacted] was standing by the medication cart, facing the Service Recipient. LPN [redacted] told the Service Recipient to "stop playing" and get off the floor. The Service Recipient did not respond and seemed angry. She did not answer RN [redacted] inquiries as to what happened. Both nurses then assisted the Service Recipient to get up off of the floor and she quickly took her medication and walked away. (Justice Center Exhibit 11)

13. Shortly thereafter, the Service Recipient, who was talking to Service Recipient B, was approached by [redacted] and she disclosed to him that a nurse had just grabbed her by the neck and pushed her to the floor. (Justice Center Exhibit 18)

14. [redacted], the Service Recipient and Service Recipient B then approached the medication area, where the two nurses were still working. A confrontation ensued, with the Service Recipient angrily accusing LPN [redacted] of pulling her by the neck and pushing her down. The Service Recipient was clearly agitated and upset. After a short time, the situation deescalated when LPN [redacted] retreated from the area, upon [redacted] request. (Justice Center Exhibit 18)

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.

[redacted]

- Pursuant to Social Services Law § 493(4), the Category of abuse 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 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 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

[redacted]

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

[redacted]

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;

[redacted]

(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

[redacted]

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 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 proven by a preponderance of evidence that the Subject has committed an act of abuse in part, by pushing the Service Recipient to the floor. Such act does constitute category 3 abuse. The Justice Center has not proven that the Subject pulled the Service Recipient by her neck.

The issue in this case is whether LPN [redacted] conduct constituted abuse and/or neglect under SSL § 488(1)(a), when she pulled the Service Recipient by her neck during an argument and pushed her to the floor on [redacted], as alleged in the Report of Substantiated Finding.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation (Justice Center Exhibits; 15 in total). The investigation underlying the substantiated report was conducted by OPWDD Internal

[redacted]

Investigator, [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center.

LPN [redacted] presented two documents. (Subject Exhibits 1 and 2) She did not testify on her own behalf, nor did she have any other witness testify.

With respect to the substantiated allegation that LPN [redacted] had pulled the Service Recipient by the neck, no credible evidence was presented by the Justice Center. In fact, during the hearing, Justice Center witness, [redacted], testified that the only act that she concluded that LPN [redacted] had committed was that of pushing the Service Recipient to the floor, and that, in her view, there was insufficient evidence that LPN [redacted] had pulled the Service Recipient by the neck. (Testimony of [redacted])

Accordingly, the substantiation of that part of the allegation, that LPN [redacted] pulled the Service Recipient by her neck, is hereby reversed.

The remaining allegation is that, on [redacted], LPN [redacted] pushed the Service Recipient to the floor. Because there were no reliable witnesses to the incident and LPN [redacted] chose not to testify, the only evidence that was provided at the hearing was hearsay.

Hearsay evidence 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).

The evidence comprised mainly of third party documents and statements, shows that the Service Recipient had told some people that she had fallen on her backside, while she had told others that she had been pushed to the floor by LPN [redacted].

The Nurses Log Day Shift, dated [redacted], notes that the Service Recipient reported a "fall on buttock [sic] - no injury" The nurse who wrote the notation was not identified

[redacted]

and was not interviewed by [redacted]. (Justice Center Exhibit 14)

The Consumer Injury Locator Sheet (a blank diagram of a body) dated [redacted], shows no injuries noted and states that "[redacted] stated that she fell on her backside (buttocks)." The person who wrote the notation was not identified and was not interviewed by [redacted]. (Justice Center Exhibit 16)

The Clinical Nursing Notes, dated [redacted], state that "... 8:45 am...fall to floor on buttocks. She denies pain/discomfort. No orders." The nurse who wrote the notation was not identified and was not interviewed by [redacted]. (Justice Center Exhibit 17)

The Minor Occurrence Report and Addendum, dated [redacted], indicates that at 8:45 am, the Service Recipient approached DSA [redacted] and disclosed that she "...fell on her backside." The second page indicates that the Service Recipient was seen by a doctor, identified in the Investigative Report (Justice Center Exhibit 8) as Dr. [redacted]. Dr. [redacted] wrote in the addendum that "Occurrence reported. No injury observed..." (Justice Center Exhibit 5)

The Investigative Report indicates that Dr. [redacted] told [redacted] that there were no injuries, but that the Service Recipient complained about pain in her buttocks. She further stated that the Service Recipient "...was agitated and ambivalent because she was upset..." and that she "...was unable to obtain any information about the incident from the Service Recipient." (Justice Center Exhibit 8)

The Night Shift Core Log, dated [redacted], notes that the Service Recipient reported to DSA [redacted] that "she fell on her backside" and that she reported to [redacted] that LPN [redacted] had "pushed her down." (Justice Center Exhibit 12)

[redacted] provided a statement to [redacted] on [redacted], that the Service Recipient had told him that LPN [redacted] had "... pulled me by the neck and threw me down on the floor." [redacted] statement describes how the Service Recipient's demeanor was

[redacted]

extremely angry and upset when she complained to [redacted] and during the subsequent confrontation with LPN [redacted]. (Justice Center Exhibit 18)

The OPWDD Incident Report, dated [redacted], notes that when the Service Recipient was questioned by the NYPD officers later that day, "...she stated that she was pushed down by LPN [redacted]. They were having an argument ..." (Justice Center Exhibit 6)

[redacted] Investigative Report indicates that [redacted] interviewed the Service Recipient on [redacted]. The Report states that the Service Recipient was "reluctant" to provide information and that she would not answer when asked for the names of the nurses who were present at the time of the incident. The Report states that she did say that "...it was time for medication and she cursed at the nurse...because she was upset. The nurse pushed the Service Recipient back and she fell on her buttocks." (Justice Center Exhibit 8)

The Service Recipient's statements that she fell on her behind do not seem to be entirely consistent with her disclosures that she was pushed by LPN [redacted]. However, the simple fact is that in both of the Service Recipient's versions, she wound up falling onto the floor on her backside.

In support of the Service Recipient's statements that she fell on the floor as a result of having been pushed, RN [redacted] signed statement indicates that she saw the Service Recipient sitting on the floor. While she did not observe LPN [redacted] push the Service Recipient to the floor, when RN [redacted] returned from chasing the Service Recipient A who had taken the hand sanitizer, she saw the immediate aftermath of incident;

> "When I arrived back to Area B, I saw the Service Recipient sitting on the floor with her back against the wall, legs straight out in front of her. [redacted] was standing by the cart facing the Service Recipient telling her to get up. We both were speaking with the Service Recipient to see if she was hurt & assisted in getting her up from the floor. I could tell the Service Recipient was angry because she was sitting on the floor pouting..." (Justice Center Exhibit 11)

The fact that the Service Recipient was seen sitting unhappily on the floor by a credible

[redacted]

disinterested staff member witness is a critical part of the Justice Center's case.

In the [redacted], audio recording of [redacted] interview of LPN [redacted] LPN [redacted] was asked if she saw the Service Recipient fall on the floor and LPN [redacted] answered "no." LPN [redacted] was then asked if she saw the Service Recipient on the floor at any time on that date in the medication area and LPN [redacted] answered, "no." LPN [redacted] was asked if she had any idea why the Service Recipient was cursing at her when she came back to the medication area with [redacted] on that date and LPN [redacted] answered, "no." (Justice Center Exhibits 8 and 19)

LPN [redacted] denial that she saw the Service Recipient on the floor is in direct conflict with the evidence of RN [redacted]. Since there is a pivotal discrepancy in the two versions of events, only one of them can be a truthful account. LPN [redacted] had a strong motive to fabricate to preserve her employment. RN [redacted] had no reason to fabricate, nor did she have any stake in the outcome of the investigation. Accordingly, RN [redacted] statement is credited evidence and LPN [redacted] evidence is not credited. Furthermore, because LPN [redacted] did not answer all of [redacted] questions truthfully, her denial that she pushed the Service Recipient to the floor is also deemed unreliable.

Lastly, upon LPN [redacted] failure to testify, the Administrative Law Judge presiding over the hearing is vested with the authority to draw a negative inference. However, even in the absence of such an inference, there is sufficient evidence in the record to conclude that LPN [redacted] pushed the Service Recipient to the floor.

In the final analysis, based on the disclosures made by the Service Recipient and her degree of upset after the incident, together with the fact that the Service Recipient was seen on the floor, it is concluded that LPN [redacted] did push the Service Recipient with enough force that the Service Recipient fell on her backside onto the floor.

The act of pushing the Service Recipient committed by LPN [redacted] constitutes abuse

[redacted]

under SSL§488(1)(a) as it was "... conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury... and impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment." The language of SSL§488(1)(a) is very specific and clearly contemplates the type of situation as has arisen in this case.

The Justice Center has met its burden of proving 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. The substantiated report will not be amended or sealed.

The conduct alleged and the substantiation of the report having both been determined, pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act cited in the substantiated report constitutes the Category of abuse or neglect set forth in the substantiated report.

Pursuant to SSL § 493(4), the act cited does fit within the meaning of a Category three abuse or neglect, that is, "...abuse or neglect by custodians that is not otherwise described in categories one and two."

A substantiated category three finding of abuse or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that she has a substantiated category three report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496 (2). This report will be sealed after five years.

DECISION: The request of [redacted] that the substantiated report [redacted] dated [redacted] be amended and sealed is affirmed with respect to the allegation that she pulled the service recipient by her neck.

[redacted]

The request of [redacted] that the substantiated report [redacted] dated [redacted] be amended and sealed is denied with respect to the allegation that she pushed the service recipient to the floor. The Subject has been shown by a preponderance of the evidence to have committed abuse.

The substantiated report properly determined that the Subject's abuse of the service recipient constituted a Category three finding of abuse.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Bureau.

DATED: January 8, 2015
Spring Valley, New York