

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

In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

**FINAL
DETERMINATION
AFTER HEARING**

Adjud. Case #:

[REDACTED]

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

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

[REDACTED]
[REDACTED]
[REDACTED]

██████████

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

ORDERED:

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

The substantiated report is properly categorized, as a Category 3 act.

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

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

DATED: April 6, 2016
Schenectady, New York



David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjud. Case #:

[REDACTED]

Before:

Mary Jo Lattimore-Young
Administrative Law Judge

Held at:

Administrative Hearings Unit
New York State Justice Center for the Protection
of People with Special Needs
1200 East and West Road
West Seneca, New York 14224
On: [REDACTED]

Parties:

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

Administrative Appeals Unit
New York State 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]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

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

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

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

Allegation 1

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian, you committed neglect when you failed to provide proper supervision to service recipients by falling asleep while on duty and failing to do the required bed checks.

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

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

4. The facility, located at [REDACTED], is an [REDACTED] for adults and provides twenty-four hour supervision. The facility is operated by [REDACTED], a not-for-profit corporation and is certified by the New

York State Office for People With Developmental Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, there were five female Service Recipients who resided at the [REDACTED] ranging in ages from approximately forty years of age to eighty-seven years of age. Each of the Service Recipients had her own Individual Plan of Protective Oversight (IPOP), which the staff was required to follow. (Justice Center Exhibits 9 through 13)

6. At the time of the alleged neglect, the Subject had been employed by [REDACTED] as an [REDACTED] Specialist for approximately ten months. She had been assigned to work at the [REDACTED] for about two months prior to the alleged incident. On [REDACTED], the Subject and staff member A worked the overnight shift from 11:00 p.m. until 7:00 a.m. Staff was responsible for conducting bed checks throughout the night at various time intervals and further assisting the five residents according to their IPOPs. Although the Subject was not formally assigned the duty of caring for just one particular service recipient, the Subject that night, assumed the responsibility of caring for Service Recipient 1. Staff member A undertook the responsibility for providing care to Service Recipient 2. The other three service recipients were independent and staff was expected to assist them as necessary. The Subject, however, was custodian of all of the service recipients by virtue of her employment. (Hearing testimony of the Subject, Interrogation interview of staff member A; Justice Center Exhibits 7, 9-14)

7. At the time of the alleged incident, Service Recipient 1 was approximately forty-seven years old with a diagnosis of Epilepsy/Seizure Disorder and other medical conditions. Service Recipient 1 utilized a wheelchair for mobility and needed nighttime assistance from staff to ambulate to the bathroom. A bed pad alarm¹ was installed on Service Recipient 1's bed to let staff know when she leaves her bed at night to use the bathroom. She used a brief to protect

¹ The bed pad alarm is weight released activated. (Hearing testimony of [REDACTED] Investigator [REDACTED])

against incontinence and had recently had hip surgery. Service Recipient 1's IPOP stated that she was to be toileted every two hours to ensure dryness and the brief was to be changed when wet or soiled. Her IPOP further reiterated her physician's orders that she was to be "re-positioned every two hours," and specifically noted that staff was to refer to the "procedure record." The procedure record contained additional information regarding Service Recipient 1's care and also served to demonstrate staff's compliance with her IPOP by requiring staff to initial and document completion of the bed check procedure form every two hours, after staff had performed the required toileting and re-positioning tasks. The bed check form was stored in a binder on site which the Subject had access to.² (Hearing testimony of [REDACTED] Investigator [REDACTED]; Justice Center Exhibits 5, 8 and 10) Service Recipient 1's IPOP also required staff to conduct bed checks every hour while she was asleep in her bedroom to ensure that the wedge (pillow) was "in proper position." The pillow was required to be in between Service Recipient 1's legs, in order to prevent her from crossing her legs while she slept.

8. Service Recipient 2 is a verbal eighty-five year old, with diagnoses of Diabetes, external Hemorrhoids, Dysphagia, Diverticulitis, Hearing Loss/Hearing Aid and a Heart condition which required the implantation of a pacemaker in [REDACTED] 2009. Service Recipient 2 required staff assistance to help her ambulate to the bathroom. Additionally, a motion sensor device was installed in her bedroom to alert staff when she made attempts to arise from her bed. If the motion sensor is activated, staff is required to respond by providing field of vision supervision of Service Recipient 2, along with close "contact guard" assistance when she ambulates. She also may require verbal cues in a fire evacuation situation. (Hearing testimony of [REDACTED] Investigator [REDACTED] and Justice Center Exhibit 11)

² At the time of the incident, Service Recipient 1 was the only resident in the [REDACTED] whose bed checks every two hours for toileting and re-positioning had to be documented on the "procedure record" (or bed check forms) as referenced in her IPOP. (Justice Center Exhibit 10)

9. Service Recipient 3 is an independent sixty year old person who is able to verbally express her wants and needs. She has diagnoses of Dementia, Seizure disorder, Congestive heart failure and sleep apnea. Staff is required to conduct bed checks every hour while Service Recipient 3 is sleeping to ensure that her CPAP and oxygen machine are properly functioning. If she is unsteady when ambulating, staff may provide “close proximity up to contact guard” assistance as needed. She may also need verbal prompts in a fire evacuation situation. (Hearing testimony of [REDACTED]. Investigator [REDACTED]; Justice Center Exhibit 5, page 3; Justice Center Exhibit 9)

10. Service Recipient 4 is an independent forty-seven year old who is able to verbally report factual information. She has a diagnosis of chronic kidney disease. Service Recipient 4 experiences overnight incontinence while sleeping and may not independently get out of bed to clean up, or change her clothes. Staff is required to conduct bed checks for Service Recipient 4 every two hours throughout the night to verbally prompt her to use the bathroom, wash and change her clothes if they are soiled. She may need verbal cues to watch where she is going if she ambulates in an unsafe fashion. (Hearing testimony of [REDACTED] Investigator [REDACTED]; Justice Center Exhibit 5, page 3; Justice Center Exhibit 12)

11. Service Recipient 5 is a verbal fifty year old who is able to report some factual information. She has diagnoses of Seizure disorder, Impulse/Mood disorders and other medical conditions. Due to Service Recipient 5’s Seizure disorder, her physician ordered that a monitor be placed in her bedroom with the receiver in the living room as well as an additional receiver that staff can carry with them to be utilized in supervising Service Recipient 5 while she is sleeping. Staff is required to check on her every two hours while she is sleeping to ensure her

“chux” under pad³ is dry and to provide “close proximity up to contact guard” assistance when she ambulates on uneven, or slippery surfaces. She also may need verbal prompts in a fire evacuation situation. (Justice Center Exhibit 13)

12. At approximately 4:00 a.m. on [REDACTED], the House Manager along with Manager 2 arrived at the [REDACTED] to conduct an unannounced visit at the premises. Upon entering the [REDACTED], they went into the living room and found both staff members asleep. The Subject was lying on the couch asleep, snoring with her head on a pillow and a blanket covering her. The House Manager woke the Subject and sent her home. (Hearing testimony of the Subject, [REDACTED] Investigator [REDACTED]; Justice Center Exhibits 5 and 19)

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 and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. [SSL § 492(3)(c) and 493(1) and (3)] Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and neglect presently under review was substantiated. A “substantiated report” means a report “... wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred...” [Title 14 NYCRR 700.3(f)]

³ A “chux” pad is a kind of waterproof pad placed under the service recipient to prevent leakage.

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

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

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

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

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

If the Justice Center proves the alleged abuse and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be

██████████ determined whether the act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject breached her custodial duty and committed the acts described as neglect when she fell asleep while on duty and failed to perform the required bed checks during her overnight shift. (Hearing testimony of the Subject; Justice Center Exhibits 8 and 10)

The Service Recipients required staff supervision and assistance when ambulating. Additionally, their IPOP's dictated special procedures to evacuate the Service Recipients from the ██████████ in the event of an emergency. (Justice Center Exhibits 9 and 10) There is a preponderance of evidence in the record that the Subject's neglect was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipients.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-19) Justice Center Exhibit 19 is an audio CD consisting of the investigative interviews of the House Manager, Manager 2, Service Recipient 3, Service Recipient 4, staff member A, and the Subject's interrogation interview. The investigation underlying the substantiated report was conducted by ██████████ Investigator ██████████, who was the only witness that testified at the hearing on behalf of the Justice Center.

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

██████████

In this case, the issue as to whether or not the Subject was asleep during her assigned overnight shift at the ██████ is undisputed. However, there is a dispute as to whether the required bed checks were performed. The Subject claims that she performed the required bed check at 2:00 a.m. even though at 4:00 a.m. the managers found her asleep.

The Justice Center's central evidence is the recorded interviews of the eyewitness accounts of the House Manager and Manager 2 obtained during the investigation, the Subject's own recorded interrogation and her hearing testimony admitting that she fell asleep while on duty, which was an act that she knew was contrary to ██████████ policies. Staff member A's recorded interrogation, in which she admitted that she and the Subject had fallen asleep during their overnight shift while watching a movie, is credited evidence. (Hearing testimony of the Subject; Justice Center Exhibits 17 and 19)

The recorded interviews of the House Manager and Manager 2 were consistent, extremely detailed, and are credited evidence. Both the House Manager and Manager 2 told ██████████ Investigator ██████████ that at about 4:00 a.m. on ██████████ they had conducted an unannounced visit at the ██████. Upon entering the ██████, they found the two assigned staff members sleeping in the living room with the DVD player showing the play screen on the television, as if staff had watched a movie. The Subject was on the couch sleeping with a blanket and pillow. The Subject was heard snoring by Manager 2. Staff member A was asleep on the recliner covered by a blanket. The House Manager and Manager 2 checked on the Service Recipients and found them all asleep in their bedrooms. The House Manager then tapped on the Subject to awaken her and sent her home. Staff member A was also awakened and told to leave as well. The House Manager and Manager 2 attended to the care of the service recipients. They found several of the Service Recipients to be "drenched" in urine, making it unlikely that the

Service Recipients were checked or changed at the 2:00 a.m. hour as the Subject maintains. Moreover, Service Recipient 2 had three “chux pads” underneath her, making it most likely that instead of changing Service Recipient 2, a “chux” pad was simply thrown under her. Service Recipient 4, who was required to be checked every two hours, was also found to be wet.

During the Subject’s interrogation and hearing testimony, she stated that she checked and changed Service Recipient 1 at midnight. The Subject further stated that when she checked Service Recipient 1 again at 2:00 a.m. she did not need to be changed because she was not wet. Although the Subject claims she properly performed the bed checks, the procedure record shows that no entry was made for the scheduled 2:00 a.m. bed check. (Justice Center Exhibit 8)

The Subject asserted that because she was inadequately trained, she was unaware that she was required to initial the bed check forms or procedure record for Service Recipient 1 every two hours. This assertion lacks merit because Service Recipient 1’s IPOP specifically references “see procedure record” in that part of Service Recipient 1’s IPOP which discusses the required bed checks every two hours. (Justice Center Exhibit 10) Therefore, the Subject should have known that she was required to document the bed checks accordingly. If the Subject had referred to and reviewed the procedure record, she would have seen the clear instructions regarding Service Recipient 1’s bed checks every two hours highlighted in bold lettering at the top of the bed check forms. She also would have seen that other staff members had initialed the procedure record every two hours on prior days. (Hearing testimony of the Subject; Hearing testimony of [REDACTED] Investigator [REDACTED]; Justice Center Exhibits 7, 8, 10 and 14)

In her testimony, the Subject alleged that she had made comments about the House Manager’s relative who also works at the [REDACTED]. As a result, the Subject alleged that the House Manager disliked her for personal reasons, even though they had only limited contact. The

Subject testified that their contentious relationship fueled an effort on the House Manager's part to target her to be terminated and that the statements of the House Manager should not be given any weight. The Subject also raised a number of complaints centering on her perception that she had been unfairly targeted and treated by her employer. In any event, none of the Subject's allegations were significantly persuasive or relevant.

The Subject testified that she had taken Benadryl on the evening at issue to combat her allergies. The Subject testified that she was aware that the Benadryl would make her drowsy, yet she took it anyway. The Subject acknowledged that taking the Benadryl may have contributed to her falling asleep. The Subject also testified on cross-examination that she was aware that it was against [REDACTED] policy to fall asleep while working.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged in that the Subject fell asleep while supervising the Service Recipients. Because these Service Recipients required supervision throughout the Subject's overnight shift, even a brief period of sleeping under these circumstances was likely to have resulted in physical injury or serious or protracted impairment of the Service Recipients' physical, mental or emotional condition.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act. A substantiated Category 3 finding of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the

VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496 (2). This report will be sealed after five years.

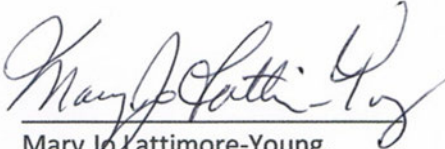
DECISION:

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

The substantiated report is properly categorized, as a Category 3 act.

This decision is recommended by Mary Jo Lattimore-Young,
Administrative Hearings Unit.

DATED: March 25, 2016
West Seneca, New York


Mary Jo Lattimore-Young,
Administrative Law Judge