

**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
AND ORDER
AFTER HEARING**

Adjud. Case #:

[REDACTED]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

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: December 28, 2017
Schenectady, New York



David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[REDACTED], Subject
Lawrence H. Schaefer, Esq.

**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:

John T. Nasci
Administrative Law Judge

Held at:

New York State Office Building
44 Hawley Street, Room 703
Binghamton, New York 13901
On: [REDACTED]

Parties:

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

[REDACTED]

By: Lawrence H. Schaefer, Esq.
Lippes Mathias Wexler Friedman LLP
54 State Street, Suite 1001
Albany, New York 12207

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], of neglect by the Subject of a Service Recipient.

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

Allegation 1

It was alleged that on dates between [REDACTED], at the [REDACTED], located at [REDACTED], while a custodian, you committed neglect when you failed to seek additional medical care and/or follow-up for a service recipient.

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, the [REDACTED], located at [REDACTED], is a [REDACTED] facility for the treatment of adult service recipients with developmental disabilities who have severe behavioral issues or who have

committed criminal offenses. The [REDACTED] is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [REDACTED], OPWDD Investigator 1 (the Investigator))

5. At the time of the alleged neglect, the Subject was employed by the [REDACTED] as a Registered Nurse 2 (RN2) and had been employed by the facility for ten years. The Subject was regularly assigned to work the overnight shift at the [REDACTED], which started at [REDACTED] and ended at [REDACTED] the next day. During the dates at issue in this proceeding, the Subject was the only RN on duty during her shift. (Justice Center Exhibit 32: audio recording of OPWDD interrogation of Subject; and Hearing testimony of the Subject) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was a thirty-four year old male and had been a resident of the facility for approximately two years. The relevant diagnoses of the Service Recipient included impulse control disorder, schizoaffective disorder, mental retardation, cerebral palsy and pseudo-seizure disorder. (Justice Center Exhibits 16 and 18)

7. The [REDACTED] staff were required to conduct a body check of service recipients following all restraints. However, [REDACTED] staff were not allowed to conduct a body check on service recipients who were sleeping or who refused to submit to a body check. (Justice Center Exhibit 32: audio recording of OPWDD interrogation of Subject; and Hearing testimony of the Subject)

8. During the [REDACTED] overnight shift, sometime after midnight, the Service Recipient assaulted staff and was placed in a SCIP supine restraint. After the restraint, the Subject completed a body check of the Service Recipient at 12:50 a.m. and made

the following note of her observations of his left hand: "... back of hand swollen. 0 bruising, normal ROM ..." (Justice Center Exhibits 15 and 32: audio recording of OPWDD interrogation of Subject; Subject Exhibit A; and Hearing testimony of the Subject)

9. After the body check, the Service Recipient was taken to the facility sally port to meet with the New York State Police who came to the facility to investigate the Service Recipient's assault on staff. While in the sally port, the Service Recipient assaulted the New York State Police investigators and the facility staff who were with him, resulting in the staff placing the Service Recipient in a SCIP supine restraint. While in the sally port, each time the Service Recipient was released from the restraint, he assaulted the New York State Police investigators and staff. Because of his continual assaults, the Service Recipient was placed in a SCIP supine restraint five times while in the sally port. (Justice Center Exhibits 15 and 32: audio recording of OPWDD interrogation of Subject; Subject Exhibit A; and Hearing testimony of the Subject)

10. Thereafter, the Service Recipient was returned to his housing unit and fell asleep on the sofa. Because the Service Recipient slept the remainder of the night shift, the Subject was not able to complete another body check on him. The Subject made the following entry in the Nursing Notes: "day shift to f/u L hand swelling." (Justice Center Exhibits 15 and 32: audio recording of OPWDD interrogation of Subject; and Hearing testimony of the Subject) The Subject also wrote in her Night Shift report the following: "Left back of hand swollen, no bruising, normal ROM and hand grip," and "He needs a body check." (Subject Exhibit A)

11. On [REDACTED], at 2:54 p.m., the day shift RN performed a body check on the Service Recipient and made the following entry in the Nursing Notes: "L hand still has some swelling, able to bend and wiggle fingers ..." (Justice Center Exhibits 15)

12. The Subject had pass days and did not work on [REDACTED].

(Justice Center Exhibits 15, 29 and 32: audio recording of OPWDD interrogation of Subject; and Hearing testimony of the Subject)

13. On [REDACTED], at 7:42 p.m., the Service Recipient was transported to [REDACTED] for a psychiatric evaluation and returned to the facility at 11:00 p.m. (Justice Center Exhibits 15, 21 and 22; and Hearing testimony of the Subject)

14. On [REDACTED], the Service Recipient fell twice during the day, after which staff performed body checks and noted no new injuries. During the evening shift, the Service Recipient assaulted staff and was placed in a SCIP restraint twice. A body check was performed after the first restraint and no new injuries were noted. A body check was not performed after the second restraint. (Justice Center Exhibit 15)

15. During the Subject's [REDACTED] overnight shift, at 11:19 p.m., the Service Recipient assaulted staff and was placed in a SCIP supine restraint. The Service Recipient calmed and was released. At 12:30 a.m., the Service Recipient assaulted staff again and again was placed in a SCIP supine restraint. The Subject was not able to perform a body check due to the Service Recipient's heightened state of agitation and his refusal to submit to a body check. At 2:30 a.m., the Service Recipient fell asleep and the Subject was not able to do a body check for the remainder of the overnight shift. (Justice Center Exhibit 15 and Hearing testimony of the Subject)

16. On [REDACTED], during the day shift, the Service Recipient was examined by a doctor and ordered to the hospital emergency room for a general medical evaluation. The Service Recipient was transported to the hospital at 3:30 p.m. (Justice Center Exhibit 15 and Hearing testimony of the Subject)

17. During the Subject's [REDACTED] overnight shift, the Service Recipient arrived back from the hospital at 11:15 p.m. The Subject performed a body check and noted no new injuries in the Nursing Notes. At 12:48 a.m., the Service Recipient assaulted staff and was placed in a SCIP supine restraint. The Subject was not able to perform a body check due to the Service Recipient's heightened state of agitation. At 3:35 a.m., the Subject was able to perform a body check and noted the following: "slight swelling to L back of hand as per observation & body check on [REDACTED]." At 4:10 a.m., the Service Recipient assaulted staff again and was placed in a SCIP supine restraint. Thereafter, the Subject was not able to perform a body check due to the Service Recipient's heightened state of agitation. (Justice Center Exhibits 15 and 32: audio recording of OPWDD interrogation of Subject; Subject Exhibit B; and Hearing testimony of the Subject)

18. On [REDACTED] at 2:00 p.m., the Service Recipient assaulted staff and was placed in a SCIP supine restraint. Thereafter, a body check was performed by the day shift RN and no new injuries were noted. Later in the day shift, the day shift RN performed an evaluation of the Service Recipient's left hand and noted in the Nursing Notes no bruising, redness or edema, and found normal range of motion (ROM) and no indication of the Service Recipient suffering from pain. (Justice Center Exhibit 15)

19. On [REDACTED], at 10:45 a.m., the day shift RN examined the Service Recipient's left hand, was concerned about persistent swelling, and called the Service Recipient's doctor to request an X-ray of the Service Recipient's hand. The doctor made the order and the day shift RN arranged for [REDACTED] to come to the facility with a portable X-ray machine to perform an X-ray of the Service Recipient's left hand. On [REDACTED], the Subject was assigned to the evening shift (3:00 p.m. to 11:00 p.m.) and [REDACTED] arrived during the start of the Subject's

shift. [REDACTED] performed the X-ray and issued a report to the Subject at 4:55 p.m. The report indicated the existence of a fracture to the 4th metacarpal bone in the Service Recipient's left hand. (Justice Center Exhibits 15 and 32: audio recording of OPWDD interview of [REDACTED] and interrogation of Subject; and Hearing testimony of the Subject)

20. On [REDACTED], the Service Recipient was examined at the [REDACTED] Hospital and diagnosed with a fracture to his 4th metacarpal bone of his left hand. (Justice Center Exhibits 8 and 22)

21. The [REDACTED] nursing staff, including the Subject, had available to them the portable X-ray services of [REDACTED] for taking X-ray film of service recipients in the case of a possible broken bone. In the past, such services had been employed during all shifts, including the overnight shift. A doctor order, requested by a RN, was necessary in order to employ the use of [REDACTED] to obtain an X-ray of a service recipient. (Justice Center Exhibit 32: audio recording of OPWDD interview of [REDACTED] and interrogation of the Subject; and Hearing testimony of the Subject)

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 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))

The neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h), as follows:

"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 neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined as follows:

(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.

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 neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged 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 neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

If the Justice Center did not prove the 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 committed an act, described as “Allegation 1” in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1 through 31) The Justice Center also presented audio recordings of the Justice Center Investigator’s interview of witnesses and interrogation of the Subject. (Justice Center Exhibit 32) The investigation underlying the substantiated report was conducted by the Investigator, who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented two documents. (Subject Exhibits A and B)

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject’s action, inaction or lack of attention breached a duty that resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipients. (SSL §488(1)(h))

The Justice Center contends that once the Subject noticed the swelling in the Service Recipient’s left hand, she had the duty to make a request of the Service Recipient’s doctor to order

an X-ray of the Service Recipient's hand, that the Subject breached her duty by failing to make the request and that, as a result of the Subject's breach, the Service Recipient was likely to suffer physical injury or serious or protracted physical, mental or emotional impairment.

The Subject argues that she consistently informed the day shift RN of the swelling in the Service Recipient's left hand and that the day shift RN was neglectful in not requesting an order for an X-ray of the hand.

The Subject admitted in her hearing testimony that the swelling which she observed in the Service Recipient's left hand, as early as [REDACTED], was cause enough for her to request the Service Recipient's doctor to order an X-ray to be performed in order to determine if there were any broken bones. She further testified that she did not request the X-ray order herself because having the portable X-ray technicians come to the facility in the middle of the night was not a normal occurrence. The Subject further testified that she was concerned for the safety of the X-ray technicians due to the Service Recipient's heightened state of agitation and highly assaultive behavior, and because she was the only RN on duty during the overnight shift. (Hearing testimony of the Subject)

However, the Subject presented no evidence that [REDACTED] policy forbid or discouraged the engagement and use of a portable X-ray company during the overnight shift. Additionally, the Subject presented no evidence that there were insufficient staff to provide security for the X-ray technicians or, if there were insufficient staff on duty, that she could not have requested additional staff for this purpose. Finally, the Subject admitted that, while it is not her usual practice to call for an X-ray during the overnight shift, she can seek an order for the employment of the portable X-ray company during the overnight shift if she has concerns, and that this has been done in the past. (Justice Center Exhibit 32: audio recording of OPWDD interrogation of the Subject; and

Hearing testimony of the Subject)

The credible evidence in the record establishes that the swelling in the Service Recipient's left hand triggered the Subject's duty to request an order from the Service Recipient's doctor for an X-ray to be performed in order to determine if there were any broken bones, that the Subject breached her duty by failing to make such a request and that the Subject's conduct was likely to result in further physical injury or serious or protracted impairment of the Service Recipient's physical condition.

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. The substantiated report will not be amended or sealed.

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.

Substantiated Category 3 findings of 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 SSL § 496 (2). The report will be sealed after five years.

DECISION:

The request of [REDACTED] that the substantiated report dated [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 John T. Nasci, Administrative Hearings Unit.

DATED: December 21, 2017
Schenectady, New York

A handwritten signature in black ink, appearing to be 'J. Nasci', written over a horizontal line.

John T. Nasci, ALJ