

**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 Elizabeth M. Devane, ALJ, of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: December 27, 2019
Schenectady, New York



Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Rachel Dunn, Esq.
[REDACTED], Subject
David Friedman, 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:

Mary Jo Lattimore-Young
Administrative Law Judge

Held at:

New York State Justice Center for the Protection
of People with Special Needs

[REDACTED]

-and-

[REDACTED]

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: Rachel Dunn, Esq. and

Thomas Parisi, Esq.

[REDACTED]

By: David Friedman, Esq.

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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for abuse (obstruction of reports of reportable incidents) and 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 abuse (obstruction of reports of reportable incidents) and 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 [REDACTED], at the [REDACTED], located at [REDACTED], while a custodian, you committed abuse (obstruction of reports of reportable incidents) when you provided a false account of events in your Preliminary Witness Statement.

This allegation has been SUBSTANTIATED as Category 2 abuse (obstruction of reports of reportable incidents) pursuant to Social Services Law § 493(4)(b).

Allegation 2

It was alleged that on [REDACTED], concerning a report of a reportable incident that occurred at the [REDACTED], located at [REDACTED], while a custodian, you committed abuse (obstruction of reports of reportable incidents) when, while being interviewed

and/or interrogated during the course of an investigation of Category 1 conduct, you intentionally made materially false statements with the intent to obstruct said investigation.

This allegation has been SUBSTANTIATED as Category 1 serious conduct pursuant to Social Services Law § 493(4)(a)(xiii).

Allegation 3

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while a custodian, you committed neglect when you failed to provide adequate medical care to a service recipient, which included not immediately seeking medical attention and/or making appropriate notifications for him while he experienced a grand mal seizure, not appropriately positioning him during his seizure episode, and/or not immediately complying with requests made by Emergency Medical Technicians.

This allegation has been SUBSTANTIATED as Category 1 neglect pursuant to Social Services Law § 493(4)(a)(ii).

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

4. [REDACTED], the facility, located at [REDACTED], is a facility for disabled individuals, and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. The service recipients who reside at the facility range in age from approximately eighteen to over fifty years old. Most, if not all, of the service recipients had been placed at the facility as a result of a family court and/or criminal court proceeding. The facility was comprised of three different units with security levels ranging from most secure to least secure. The service recipients involved in the instant matter resided in the four moderately secure residential houses collectively referred to as the [REDACTED] houses: House [REDACTED], House [REDACTED], House [REDACTED] and House [REDACTED]. Staff involved in the instant matter were assigned to work in

these four houses. (Hearing testimony of Justice Center Investigator 1¹; Justice Center Exhibits 66 A at page 664; 67, 72 and 75 - 77)

5. At the time of the alleged abuse (obstruction of reports of reportable incidents) and or neglect, the Subject had been employed at the facility since [REDACTED]. At that time, the Subject was working as a Developmental Disabilities Secure Care Treatment Aid (DDSCTA) 1 and was responsible for the direct care of the service recipients. The Subject had been trained in Strategies in Crisis Intervention - Revised (SCIP-R)² as well as first aid and CPR trainings which included the facility's seizure protocol requiring staff to place a service recipient on his side (known as the recovery position) to prevent aspiration when a seizing service recipient foams at the mouth. (Hearing testimonies of the Subject, the former Mental Hygiene Developmental Specialist Trainer (MHDST) ³ and Justice Center Investigator 1; Justice Center Exhibits 8, 21, 67, 72 and 75 - 77) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. On [REDACTED], the date of the alleged incident, the Subject, Staff 1⁴, Staff 2⁵, Staff 3⁶, Staff 4⁷, Staff 5⁸, Staff 6⁹, and Staff 7¹⁰ worked the same [REDACTED] shift. The Subject was assigned to work in House [REDACTED]. Staff 8¹¹ and the facility Registered Nurse (RN 1)¹² were also present during the shift. (Hearing testimonies of the Subject, Staff 1, Staff 2, Staff 4, Staff 5, Staff 6, Staff 7, Staff 8 and Justice Center Investigator 1; Justice Center Exhibits 37, 54,

¹ [REDACTED] is hereinafter referred to as Justice Center Investigator 1.

² SCIP-R refers to facility authorized physical restraint interventions that are maneuvers taught to staff to use to address a service recipient's behavioral episodes if SCIP-R is allowed by their treatment plans.

³ [REDACTED] is hereinafter referred to as MHDST.

⁴ [REDACTED] is hereinafter referred to as Staff 1.

⁵ [REDACTED] is hereinafter referred to as Staff 2.

⁶ [REDACTED] is hereinafter referred to as Staff 3.

⁷ [REDACTED] is hereinafter referred to as Staff 4.

⁸ [REDACTED] is hereinafter referred to as Staff 5.

⁹ [REDACTED] is hereinafter referred to as Staff 6.

¹⁰ [REDACTED] is hereinafter referred to as Staff 7.

¹¹ [REDACTED] is hereinafter referred to as Staff 8.

¹² [REDACTED] hereinafter referred to as Registered Nurse (RN 1).

67, 72 and 75 - 77)

7. At the time of the alleged abuse (obstruction of reports of reportable incidents) and neglect, the Service Recipient was an eighteen-year-old male who had been a resident in House [REDACTED] for approximately [REDACTED], placed there pursuant to a court mandate. (Justice Center Exhibit 21 at page 2) The Service Recipient had a diagnosis of a moderate intellectual disability with no psychiatric diagnoses and no psychotropic medication indicated.

8. The Service Recipient's [REDACTED] Intake and Interim Behavioral Intervention Plan (IBIP) required staff to follow the IBIP for the Service Recipient's supervision and care. The IBIP listed punching, hitting and theft as the Service Recipient's target behaviors and noted that the focus of his treatment should include social/personal adaptive skills training and anger management. Most importantly, the IBIP specified that staff was allowed to use physical restraint interventions under SCIP-R for behavioral management of the Service Recipient in the event of an "EMERGENCY only, after 1 verbal prompt" and that staff should attempt to re-direct the Service Recipient by pointing or gesturing to an adjacent area for him to remove himself from the situation and "...*Chill* and sit down." In the alternative, the IBIP allowed staff to "use 1 or 2 - person escorts/removals" of the Service Recipient under SCIP-R if it was needed to safely remove the Service Recipient to an "adjacent area" to allow him to calm down. (Hearing testimonies of MHDST and Justice Center Investigator 1; Justice Center Exhibits 21, 72 and 75 - 77)

9. In handling emergencies at the facility, all direct care staff members were required to carry on their person a key chain or hand-held fob, commonly referred to as the "[REDACTED]." Staff were required to push the [REDACTED] if they needed immediate assistance and, once activated, the facility safety officer was notified as to which staff member needed assistance as well as their exact location within the facility. The safety officer then dispatched this information over the

facility's intercom system to alert available staff to immediately report to the scene for assistance. In the event of a potential medical emergency, staff were required to call a special recorded telephone line known as Code [REDACTED] which was connected to the facility's internal telephone line and directly piped into the facility's safety office. Thereafter, the safety officer would summon emergency services and broadcast an alert throughout the facility for staff to immediately respond. (Justice Center Exhibits 66 A, 67, 72 and 75 - 77)

10. The facility's "Policy and Procedure for Suspected Head Injury," dated March 23, 1999 (Head Injury Policy), stated that staff was to "respond prudently and cautiously to suspected head injuries" involving service recipients. The Head Injury Policy, however, did not state a specific time frame as to when nursing was required to be contacted in the event of a suspected head injury. The first four items of the Head Injury Policy specifically noted that direct care staffs' responsibilities on campus were: 1.) to assess if a service recipient is "conscious or unconscious;" 2.) "not" to "move" a service recipient ("consumer") and stabilize their "cervical spine if spinal injury suspected"; 3.) to "stop any bleeding"; and 4.) to notify the "nurse." (Justice Center Exhibit 62)

11. Sports activities for the service recipients were scheduled by the facility's Recreational Therapist¹³ and were held in the gymnasium located in the [REDACTED] program area of the facility. Typically, two different houses were permitted to attend one recreational period in the gymnasium at the same time. When the recreational period ended, the service recipients walked down the hallway into their assigned homerooms to gather (or "hub up") for a head count before staff escorted them to their assigned residential houses. There were times when the facility's Hab Spec or other staff would authorize a service recipient to attend more than one recreational period,

¹³ [REDACTED] is the facility's Recreational Therapist or Habilitation Specialist (**Hab Spec**) 1.

thereby allowing a service recipient to participate in activities that involved residents from different houses. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 51, 67 - audio interview of Hab Spec 1 and Staff 8's audio interviews; 72 and 75 - 77)

12. On [REDACTED], there were two recreational periods scheduled: service recipients who lived in Houses [REDACTED] and [REDACTED] attended the first recreational period that began at 2:15 p.m. and ended at 3:00 p.m. and Houses [REDACTED] and [REDACTED] from 3:00 p.m. to 3:45 p.m. At the end of the first recreational period, with the exception of Service Recipient B, the Subject escorted the rest of the service recipients from the gym back to the House [REDACTED]. Since the Service Recipient lived in House [REDACTED], he attended the first recreational period along with his housemates. However, on that day, the Hab Spec 1 allowed the Service Recipient and Service Recipient B, who lived in House [REDACTED], to stay over at the end of the first recreation period and attend the second recreational period. At the end of the second recreation period, the Service Recipient was to report to the Computer Room in order to "hub up" and then be escorted by staff to his own residence at House [REDACTED]. Service Recipient B was to report to House [REDACTED] homeroom and then be escorted to his own House [REDACTED]. (Hearing testimony of Justice Center Investigator 1 and Justice Center Exhibits 47 - 49, 51, 67 - audio interviews of Hab Spec 1, Service Recipient D, Staff 8's second audio interview; 72 - and 75 - 77)

13. The second recreational period, however, abruptly ended (sometime between 3:00 p.m. and 3:15 p.m.) because the Service Recipient became upset with regard to a sporting activity. The Service Recipient then became further agitated because the recreation period had prematurely ended. At some point, the Service Recipient, while still in the gym, called Staff 4 a "bitch" or "whore." Other service recipients were present in the gym and overheard the Service Recipient's demeaning comment about Staff 4. (Justice Center Exhibits 66 A at pages 258 – 278; 66 B, and

67 - audio interviews of Staff 3, Staff 8, Hab Spec 1 and Service Recipients A, C, F, G and H) Staff 1, who was also still present in the gymnasium, either heard the Service Recipient make the derogatory comment to Staff 4 or somehow became aware that the comment was made from other staff or service recipients. The service recipients then began to transition, exiting the gymnasium with staff and walking down the corridor toward their respective homerooms. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 51, 67 - audio interviews of Hab Spec 1, Staff 3, Staff 8 and Service Recipients A and B; 72 and 75 - 77)

14. While the service recipients were still transitioning into their assigned homerooms, Staff 1 walked down the hallway behind the Service Recipient who was headed towards the Computer Room. As they walked down the hallway, Staff 1 agitated the Service Recipient by pushing him while the Service Recipient kept telling Staff 1 to stop it. After the Service Recipient entered the Computer Room, Staff 1 followed. Staff 1 at some point stated out loud, and within ear shot of Service Recipient C that Staff 1 was going to teach the Service Recipient a lesson. (Justice Center Exhibit 67 - audio interviews of Service Recipients A and C) Staff 2 and Staff 4 were also in the Computer Room at the time. The Service Recipient then got upset and tried to leave the room. Staff 1 and Staff 2 ran out into the hallway after the Service Recipient. Staff 2 stood in the doorway. Staff 1 told the Service Recipient to get back in “the fucking class” but the Service Recipient refused. Staff 1 then tried to grab or push the Service Recipient to direct him back into the Computer Room. The Service Recipient told Staff 1 not to touch him. (Justice Center Exhibit 67 - audio interviews of Service Recipients C and G)

15. When the Service Recipient eventually entered the Computer Room, he was upset and kicked an object (either a garbage can or fan) toward the back of the room where there were no other service recipients. (Justice Center Exhibit 20 - photographs at page 5) Staff 1 re-entered

the Computer Room, approached the Service Recipient and, as they stood face to face, the Service Recipient began to yell at Staff 1. Upon hearing the commotion at approximately 3:15 p.m., Staff 8 left House [REDACTED] homeroom, headed down the hall towards the Computer Room and entered the Computer Room. Staff 8 observed the Service Recipient and Staff 1 standing face to face and arguing in the back of the room. At some point, Staff 3, also heard the commotion and entered the Computer Room. Service Recipients A, C, E and G, as well as Staff 2, Staff 3, Staff 4 and Staff 8, were present in the room but were not near Staff 1 and the Service Recipient at that time. The Subject had remained at the residential cottage (House [REDACTED]) at the time. (Hearing testimonies of the Subject and Justice Center Investigator 1; Justice Center Exhibits 66 A at pages 352 - 373 and 67 - audio interviews of Staff 3, Staff 8 and Service Recipients A, C and G; 72 and 75 - 77)

16. Sometime between 3:15 p.m. and 3:30 p.m., the Service Recipient continued to vocalize at Staff 1, at which point Staff 1 engaged in a football-style tackle of the Service Recipient. Staff 1 bent over, rammed his shoulder into the left side of the Service Recipient's mid-section and then, grabbed the outside of the Service Recipient's knees, causing the Service Recipient to lift upwards, fall backwards and hit the back-crown portion of his head on the hard floor. Staff 1 then fell on top of the Service Recipient. When the Service Recipient fell, the impact of the back of his head slamming onto the floor emitted a loud noise that could be heard by staff and service recipients in the Computer Room. (Justice Center Exhibit 67 - audio interviews of Staff 3 and Staff 8, Service Recipients A, C and G)

17. As the Service Recipient laid on his back, Staff 1 re-positioned himself and grabbed the Service Recipient's right arm to hold him down. Staff 2 grabbed the Service Recipient's left arm and Staff 3 grabbed onto the struggling Service Recipient's legs to hold them down. Staff 8, who remained in the room and was about ten feet away from where the Service Recipient was

lying, observed Staff 1 placing his forearm tightly across the Service Recipient's neck, and then began swearing and yelling at the Service Recipient that he better respect females. The Service Recipient struggled to breathe because of Staff 1's chokehold and his facial coloring had changed to a reddish-grey. Thereafter, Staff 1 released his chokehold of the Service Recipient and repositioned his hold by grabbing the Service Recipient's right arm. (Justice Center Exhibit 67 - audio of Staff 8's second interview and Service Recipient G)

18. While Staff 1, Staff 2 and Staff 3 continued to maintain their hold, the struggling Service Recipient remained lying on his back on the floor. At some point, the yelling and kicking Service Recipient began to black out and experience seizure-like symptoms while staff continued to hold him down. (Justice Center Exhibit 67 - audio interviews of Staff 8, Service Recipients A and G)

19. At approximately 3:30 p.m., while the Service Recipient's seizure continued as he laid on his back on the floor and at some point, foam began to expel from his mouth. Present in the room were Staff 1, Staff 2, Staff 3, Staff 4 and Staff 8. The Service Recipient's seizure continued. At this time, the Subject remained at the residential cottage (House ■■■). (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 67 - Staff 3's audio interview and Staff 8's second audio interview; 72 and 75 - 77)

20. Finally, Staff 4 pressed her ■■■ which registered on the Safety Officer's computer at 3:47 p.m. and Staff 5, the hall monitor, immediately responded and entered the room. (Justice Center Exhibit 66 A at pages 110 - 115 and at pages 393 - 408) Staff 4 told Staff 5 to call the Code ■■■. Staff 5 mistakenly called Safety Officer 1 at extension ■■■ and told him that there was a medical emergency. Safety Officer 1 instructed Staff 5 to hang up and call back on the special Code ■■■ line required for medical emergencies. (Justice Center Exhibit 66 A at page

403) 911 emergency was called at approximately 3:48 p.m., Safety Officer 1 radioed and paged medical staff to immediately report to the scene. (Hearing testimonies of Staff 4, Staff 5 and Justice Center Investigator 1; Justice Center Exhibits 16, 66 A at pages 98 - 114 and at pages 388 – 409; 67 - Safety Officer 1's audio interview; 72 and 75 - 77)

21. In response to the [REDACTED] and/or Code [REDACTED], Safety Officer 2¹⁴ was the first officer to arrive at the scene. Shortly thereafter, Safety Officer 3¹⁵ entered the room and saw the Service Recipient was lying on his back during his seizure event with some of the staff kneeling around him. At some point, during the Service Recipient's seizure, Staff 3 yelled out to everyone "we're fired, we're done!" While waiting for medical responders to arrive and as the Service Recipient remained lying on his back during the seizure event, the staff in the Computer Room continued their conversations about the story they were planning to collectively tell about what happened to the Service Recipient. (Justice Center Exhibit 67 - audio interviews of Staff 3, Service Recipient A and Staff 8's second audio interview) Some of the staff took notes about the false narrative they had begun to develop. To assist in restraining the Service Recipient, Staff 8 took hold of the Service Recipient's arm from Staff 2, during which time Staff 8 overheard the other staff's conversations evincing their panic and concerns about being fired from their jobs due to the Service Recipient's seizure. During that group conversation, Staff 1, Staff 2, Staff 3, Staff 4 and Staff 8 were all in the room. Staff 6 and Staff 7 were also in the Computer Room during the group conversation, having arrived after the Service Recipient was taken to the floor. During this time, the Subject remained at House [REDACTED]. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 67 - audio interviews of the Subject, Staff 3, Staff 8, Safety Officer 3; 72 and 75 -

¹⁴ [REDACTED] is hereinafter referred to as **Safety Officer 2**.

¹⁵ [REDACTED] is hereinafter referred to as **Safety Officer 3**.

77)

22. After the [REDACTED] had been activated, but before the Code [REDACTED] was called the Subject responded from House [REDACTED] by leaving through the side door where she ran through the outdoor courtyard then entered the program building. When the Subject initially arrived at the Computer Room, the Subject momentarily stepped inside about two feet away from the doorway threshold and saw that the Service Recipient was having a seizure. The Subject asked staff if she could assist. Staff who were present told the Subject that they had enough staff there at that time but instructed her to go across the hall to House [REDACTED] homeroom to help control the other service recipients who had been removed from the room. The Subject immediately left the Computer Room and walked across the hall intending to further assist and escort the other service recipients back to their residential houses. (Hearing testimony of the Subject; Justice Center Exhibits 37, 47 - 49, 67, 72 and 75 - 77)

23. RN 1, the first medical staff person to arrive at the scene, observed the Service Recipient having a seizure, lying on his back, and saw that foam was coming from his mouth. RN 1 performed a cursory assessment of the Service Recipient and completed the [REDACTED] Body Check Form which she and Staff 7 had signed. (Justice Center Exhibit 26 at pages 1 - 2) On said Body Check Form, RN 1 had documented a "Medical Emergency Grand mal Seizure" and that "while [the Service Recipient] was on floor lying on R side¹⁶ did a quick check of...head... Ø lumps noted, Ø blood noted unable to visualize injury to head" and further stated that "asked staff if he hit his head and they stated he did not." (Justice Center Exhibit 26) RN 1's Body Check Form also did not list any injuries, lacerations, redness or bruising seen on either of the Service

¹⁶ During RN 1's investigatory interview and testimony in her criminal trial, RN 1 admitted that although she documented that the Service Recipient was lying on his right side the Service Recipient was actually lying on his back when she first arrived on the scene. (Justice Center Exhibits 66 A at page 641 and 661 - and 67)

Recipient's knuckles or the backside of his hands.

24. The facility physician¹⁷ and other nursing staff, RN 2¹⁸ and RN 3¹⁹, then arrived and they had all observed that the Service Recipient was lying on his back, exhibiting seizure-like symptoms with foam coming from his mouth. (Justice Center Exhibit 67) At some point, Safety Officer 2 had told staff to leave the Computer Room at which time many staff did and headed across the hall as the Subject was bringing the other service recipients out to escort them back to their houses. Since the other staff had been released from the Computer Room, they were able to escort the other service recipients back to their houses. At that point, the Subject saw that medical responders were in the Computer Room, so she went in the Computer Room for the second time to assist the facility physician and other medical responders by holding down the Service Recipient's legs along with Staff 7 and other staff as the facility doctor attempted to administer an IV of anti-seizure medication in the Service Recipient's right arm. The Subject also helped to prepare the Service Recipient for transport to the hospital after the EMTs arrived. (Hearing testimony of the Subject; Justice Center Exhibits 26 at page 5; 66 A at pages 646 - 665, 67, 72 and 75 - 77)

25. At approximately 4:01 p.m., the emergency response services, EMT 1²⁰ and EMT 2²¹, arrived at the scene wherein the Service Recipient was still lying on his back on the floor with staff holding him down. EMT 1 directed staff to release the Service Recipient and an unknown female staff told the EMTs that the Service Recipient may have hit his head when he fell. After treating the Service Recipient, the EMTs placed the Service Recipient on a stretcher and

¹⁷ [REDACTED] is hereinafter referred to as the **facility physician**.

¹⁸ [REDACTED] is hereinafter referred to as **RN 2**.

¹⁹ [REDACTED] is hereinafter referred to as **RN 3**.

²⁰ [REDACTED] is hereinafter referred to as Emergency Medical Technician (**EMT**) 1.

²¹ [REDACTED] is hereinafter referred to as **EMT 2**.

transported him by ambulance to the hospital. The Subject assisted the EMTs and stayed in the Computer Room until the Service Recipient was transported to the hospital then returned to House [REDACTED] and worked the remainder of her shift. Staff 8 rode in the ambulance with the Service Recipient. While in route to the hospital, although the Service Recipient was conscious, he was not coherent until a few minutes before arriving at the hospital. He kept rubbing the back of his head and EMTs noticed a three-inch circular bruise on the back of his head. The Service Recipient reported to the EMTs that he had a behavioral episode and that he hit the back of his head when staff took him down. (Justice Center Exhibit 64 at page 24) At 4:22 p.m., the Service Recipient arrived at the hospital's emergency room and Staff 8 stayed with him at the hospital. (Hearing testimonies of the Subject and Justice Center Investigator 1; Justice Center Exhibits 16, 64, 66 A at pages 551 - 594 and 609 - 683 and 66 B at pages 1 - 40 and 67 - audio interviews of Staff 3, Staff 8, the facility physician, RN 2, RN 3, EMT 2 and Safety Officer 3; 72 and 75 - 77)

26. After arriving at the hospital, the Service Recipient complained to the hospital physician²² that he had a headache and was treated for a head injury/seizure with sudden onset. The history provided to the hospital was that the Service Recipient was "being restrained by staff after he was reported to have become aggressive and kicked over fan and punched a staff member. Was taken to the ground and struck head." A Computed Tomography (CT) scan of the Service Recipient's head/brain was performed on [REDACTED] and yielded normal (or negative) results for any "acute intracranial pathology" or "skull fracture." However, the CT scan showed that the Service Recipient had sustained a hematoma (bruise) on the back of his head with "soft tissue swelling overlying the posterior aspect of the vertex." The Service Recipient had also sustained lacerations and bruises on his body. (Justice Center Exhibit 64)

²² [REDACTED], M.D. hereinafter referred to as the **hospital physician**.

27. After staff had returned to their assigned houses to finish their shifts, Service Recipients A and C overheard conversations amongst staff involved in the incident about their facility notes/documentation and observed staff passing notes to each other about the incident for review. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 54, 67 - audio interviews of Staff 3, Staff 8, Service Recipients A and C; 72 and 75 - 77)

28. While Staff 8 was at the hospital with the Service Recipient, Staff 8 telephoned the Service Recipient's father at or about 5:00 p.m. to inform him of Staff 8's concerns regarding staff's use of excessive force against the Service Recipient which caused him to hit his head on the floor then began to flop like a "fish out of water."²³ (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 67 - audio interviews of Staff 8 and the Service Recipient's Father; 72 and 75 - 77)

29. Upon discharge from the hospital at approximately 9:42 p.m. that same evening, the Service Recipient had been diagnosed with a "minor head injury" and "post-traumatic seizures" related to the incident. (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 64, 66 A at pages 222 -257; 67 - Staff 8's second audio interview; 72 and 75 - 77)

30. Sometime before 10:00 p.m., and upon returning from the hospital to the facility with the Service Recipient, Staff 8 went into the Head of Shift's office where Staff 4, Staff 6 and Staff 7 were present, along with an unidentified staff person. At that time, Staff 4 instructed Staff 8 what to document as a part of the agreed upon false narrative that staff was going to say happened and use in writing facility notes and/or statements to cover up what actually occurred. (Justice Center Exhibits 29 and 41) The agreed upon false story that staff was to advance was that the Service Recipient's behavioral episode in the gymnasium continued even after he entered the

²³ Also refer to Justice Center Exhibits 66 A - Service Recipient's Father's Trial transcript.

Computer Room, at which time the Service Recipient punched Staff 1, which warranted the SCIP-R two-person take down that was properly performed by Staff 1 and Staff 2. Also included in the falsehood was that the Service Recipient was lying properly on the floor on his “right side” (the recovery side). (Hearing testimony of Justice Center Investigator 1; Justice Center Exhibits 31 at page 4; 64 and 67 - audio interviews of Staff 3, Staff 8 and Service Recipient A)

31. At approximately 11:50 p.m., another staff nurse²⁴ performed a visual body check on the Service Recipient and noted the following injuries: six-inch superficial abrasion right side of back, approximately 1 - ½” diameter bruise left elbow, approximately 1 - ½” diameter bruise above left elbow, several red marks antecubital area and an abrasion/reddened area in the back of head. There were no injuries, lacerations, redness or bruising noted on the Service Recipient’s knuckles or the backside of either hand. (Justice Center Exhibits 26, 31 and 64)

32. The following day, [REDACTED], RN 1 conducted a medical body check on the Service Recipient. (Justice Center Exhibit 26 at pages 5 - 8) RN 1 then documented and took photographs of his physical injuries. (Justice Center Exhibit 19) The injuries noted were a 3” x 3” red abrasion to the back of his head, a 2-½” x 2-½” purple/red bruise on the right antecubital (or area in front of elbow from where blood was drawn) that RN 1 noted was due to the insertion of the IV injection/disruption of medication and left antecubital area of his head with bruises/abrasions on his back, his left elbow, back of left arm, right and left shoulder blades and mid-back. No redness, lacerations, bruises or other injuries were noted on the back of the Service Recipient’s hands or knuckles. (Hearing testimony of the Justice Center Investigator; Justice Center Exhibits 18 - 19, 66 A at pages 635 – 636; 67 - RN 1’s audio interview; 72 and 75 - 77)

33. In her [REDACTED] Preliminary Witness Statement, the Subject had stated that

²⁴ Facility RN [REDACTED] is referred to as another staff nurse.

when she entered the room the Service Recipient was on the floor and "...appeared to be seizing..." She also stated that she was then asked to go to another room for extra staff and assist with transporting the other service recipient to their houses. The Subject further reported that she was asked to come back into the Computer Room to hold down the Service Recipient as the facility physician administered the Service Recipient's IV. (Justice Center Exhibit 37)

34. During her [REDACTED] interview, the Subject told investigators that she had responded to the incident from the Cottage (House [REDACTED]) but that she could not recall whether she responded after she heard the [REDACTED] or the Code [REDACTED]. The Subject told investigators that when she arrived at the Computer Room from House [REDACTED], that she stepped inside for a moment to ask if she could assist. At that time, the Subject stated that she saw that the Service Recipient was lying on the floor facing the doorway, turned onto his right side with staff standing behind him. The Subject further told investigators that she could not recall if the Service Recipient was convulsing at that time. The Subject also stated that staff then told her that they had the situation covered so she stepped in the hallway to go across the hall intending to take the other service recipients back to their houses. The Subject explained to investigators that she never got a chance to escort the other service recipients because staff had already escorted the remaining service recipients back to their houses. The Subject stated that she then re-entered the Computer Room, at which time she assisted by holding down the Service Recipient as medical responders tried to place an IV in the Service Recipient's arm. (Hearing testimony of the Subject; Justice Center Exhibits 47 - 49 and 67 - Subject's audio interview)

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 (obstruction of reports of reportable incidents) 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))

The abuse (obstruction of reports of reportable incidents) and neglect of a person in a facility or provider agency is respectively defined by SSL §§ 488(1)(f) and (h) as:

"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.

"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(4), including Categories 1 and 2, which are respectively defined under SSL §§ 493(4)(a)(ii), (xiii) and SSL § 493(4)(b) as follows:

(a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

(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;

(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

(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.

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

If the Justice Center proves the alleged abuse (obstruction of reports of reportable incidents) and 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 neglect cited in the substantiated report constitutes the category of abuse and neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse (obstruction of reports of reportable incidents) and 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 the Category 1 level act of abuse (obstruction of reports of reportable incidents) described as Allegation 2 of the substantiated report. However, the Justice Center has not established by a preponderance of the evidence that the Subject committed the acts described as Allegation 1 and Allegation 3 of 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 - 10 and 13 - 78) The investigation underlying the substantiated report was conducted by Justice Center Investigators 1 and 2²⁵.

²⁵ [REDACTED] is hereinafter referred to as Justice Center Investigator 2. (Justice Center Exhibit 72 and 75 - 77)

Justice Center Investigator 1 and MHDST testified at the hearing on behalf of the Justice Center at the consolidated hearing for the Subject, Staff 1, Staff 2, Staff 3, Staff 4, Staff 5, Staff 6 and Staff 7 (Co-Subjects).

The Subject testified in her own behalf. Staff 1, Staff 2, Staff 4, Staff 5, Staff 6 and Staff 7 also testified during the consolidated hearing. Staff 3 waived his right to be present and did not testify at the hearing, but was represented by legal counsel. Subject Exhibits B - E were received into evidence.

The Justice Center contended that the Subject intentionally withheld material information and made materially false statements in her Preliminary Witness Statement and during her investigatory interview with the intent to impede and obstruct the investigation. (Justice Center Exhibit 37) During the investigation, the Subject used these falsities to conceal the treatment of the Service Recipient, that the Subject did not ensure that the nurse was contacted immediately to provide medical attention to the Service Recipient who fell, injured his head suffered a post traumatic seizure and that the Subject did not ensure that the Service Recipient was rolled onto his side during his seizure when foam came from his mouth to prevent aspiration.

The Subject denied the allegations contained in the substantiated report and argued at the hearing that the report should be unsubstantiated against her. The Subject had reported that she had momentarily stepped into the Computer Room after the [REDACTED] was activated and she saw the Service Recipient lying on his side, but immediately left the room because staff told her to go help the other service recipients across the hall. The Subject then reported that she returned to the Computer Room when medical responders arrived to assist them. At that time, the Subject reported to investigators that she saw foam in the Service Recipient's mouth as he laid on his back and she was holding his legs to assist the facility physician as he was trying to administer an IV in

the Service Recipient's arm. (Hearing testimony of the Subject; Justice Center Exhibits 37 and 67 - Subject's audio interview)

Notably, the record contains differing accounts as to how the Service Recipient was lying on the floor at the time of his seizure event. Most of the Co-Subjects had reported that when they noticed that foam was coming from the Service Recipient's mouth during the seizure event that staff rolled him onto his recovery side to prevent aspiration. Yet, staff was inconsistent as to whether it was the left or right side, they had turned the Service Recipient onto, and some staff did not even specify which side. Interestingly, during the hearing, Staff 1 testified that he was the one who turned the Service Recipient onto his recovery side during the seizure. (Hearing testimony of Staff 1) Additionally, none of the other staff members could specifically recall who had actually turned the Service Recipient onto his side during his seizure event. (Justice Center Exhibits 32 - 40 and 67) Staff 6 and Staff 7, the other supervisors who were present at the time, had reported to investigators that staff had rolled the Service Recipient on his side. The Subject had reported to investigators that while she momentarily stood at the doorway of the Computer Room before staff told her to leave and go across the hall to assist the other service recipients, that she observed the Service Recipient lying on his right side with his arm fully extended. In addition, RN 1 testified at trial that when she first reported to the scene that the Service Recipient was lying on his back, although on the day of the incident she wrote on the Body Check Form that the Service Recipient was on the floor lying on his right (recovery) side. Prior to the EMTs responding, the facility physician and other nursing staff, RN2 and RN 3, had all observed that the Service Recipient was lying on his back while seizing and foam was coming from his mouth. EMT 1 told investigators and also testified at trial that when she first reported to the scene, the Service Recipient was lying on his back. Similarly, EMT 2 told investigators that when he came onto the scene, he observed

that the Service Recipient was lying on his back. (Hearing testimonies of the Subject, Staff 1, Staff 2, Staff 4, Staff 5, Staff 6 and Staff 7; Justice Center Exhibits 26, 29, 32 - 38, 66 A, 66 B and 67)

The credible evidence in the record established that the Service Recipient was positioned on his back the entire episode.

Allegation 1 - Category 2 abuse (obstruction of reports of reportable incidents)

The Justice Center has not proved by a preponderance of the evidence that the Subject committed abuse (obstruction of reports of reportable incidents) when she provided a false account of events in her Preliminary Witness Statement.

In order to prove abuse (obstruction of reports of reportable incidents) as it was alleged in this report, the Justice Center must establish by a preponderance of the evidence that the Subject impeded the "... investigation of the treatment of a service recipient by ... intentionally making a false statement," and by "... intentionally withholding material information during an investigation into such a report ..." (SSL § 488(1)(f))

SSL § 488(16) defers to the definition of the term "intentionally" as it is stated in New York's Penal Law. Pursuant to New York Penal Law § 15.05(1) "...[a] person acts intentionally with respect to a result or to conduct ... when his conscious objective is to cause such result or to engage in such conduct." (PL § 15.05(1))

The credible evidence established that in her [REDACTED] Preliminary Witness Statement, the Subject did not intentionally make a false statement. (Justice Center Exhibit 37) The Subject had stated that when she entered the room the Service Recipient was on the floor and "...appeared to be seizing..." She also stated that she was then asked to go to another room for extra staff and assist with transporting the other service recipient to their houses. The Subject then

reported in her Preliminary Witness Statement that she was asked to come back into the Computer Room to hold down the Service Recipient as the facility physician administered the Service Recipient's IV. Staff 8's and Staff 7's accounts of the incident corroborated that the Subject had returned and was present in the room assisting in holding down the Service Recipient so that medical staff could try to administer his IV. (Subject's Hearing testimony; Justice Center Exhibits 37 and 67)

Given this, the record does not show that the Subject has provided a false account of events in her Preliminary Witness Statement as alleged in the substantiated report.

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the abuse (obstruction of reports of reportable incidents) alleged in Allegation 1 of the report. Therefore, Allegation 1 of the substantiated report will be unsubstantiated, amended and sealed.

Since the report as to Allegation 1 will be unsubstantiated it is not necessary to discuss whether the substantiated report constitutes the category level of abuse (obstruction of reports of reportable incidents) set forth in the substantiated report.

Allegation 2 - Category 1 abuse (obstruction of reports of reportable incidents)

The Justice Center has proved by a preponderance of the evidence that the Subject committed abuse (obstruction of reports of reportable incidents) when, while being interviewed and/or interrogated during the course of an investigation of Category 1 conduct, she intentionally made materially false statements with the intent to obstruct said investigation.

In order to prove abuse (obstruction of reports of reportable incidents) as it was alleged in this report, the Justice Center must establish by a preponderance of the evidence that the Subject impeded the "... investigation of the treatment of a service recipient by ... intentionally making a

false statement,” and by “... intentionally withholding material information during an investigation into such a report ...” (SSL § 488(1)(f))

The credible evidence established that the Subject intentionally withheld material information and provided false statements and jointly impeded the discovery, reporting or investigation of staff’s wrongful treatment and/or failures with regard to the Service Recipient’s care. The record showed that staff acted together in order to coordinate and perpetuate the false story before the incident had to be reported by Staff 6 to the AOD, by which time some of the facility documents were filed, and staff also acted together to conceal material facts as to what actually happened to the Service Recipient during and following the incident and during the on-going investigation. The record also demonstrated that the Subject and other staff involved acted with the intent to hide their misdeeds and avoid accountability by conferring with other staff to misreport the incident and use a false narrative to withhold material information during the investigation. The conduct of the Subject contributed to the concealing of the truth for over a six-month period, from [REDACTED], the date of the incident, to [REDACTED], the date of Staff 8’s second interview when he finally came forward and revealed the truth.

The record established that on the date of the incident Staff 4 had created the false narrative in her Progress Notes which she and other staff used as a guide to unify their stories. Later that evening, when Staff 8 returned from the hospital, he went into the Head of Shift’s Office where Staff 4, Staff 6, Staff 7 and another unidentified staff person were present. At that time, Staff 4 told Staff 8 part of the false narrative to write in his Preliminary Witness Statement. Thereafter, the Subject perpetuated that part of the false narrative when she told investigators during her [REDACTED] [REDACTED] interview that after she entered the Computer Room for a moment, she saw that the Service Recipient was turned on his side during his seizure. In so doing, the Subject intentionally withheld

a material fact (that the Service Recipient was on his back during the seizure) and that she intentionally made the false statement that she saw the Service Recipient on his side during the investigation of the treatment of the Service Recipient. (Hearing testimony of the Subject; Justice Center Exhibits 13, 29, 36, 67 - Subject's audio interview; 72 and 75 - 77) Consequently, the Subject intentionally impeded and obstructed the investigation by withholding material information and providing false statements during the investigation.

Given the above, it is determined that the Subject committed abuse (obstruction of reports of reportable incidents) under SSL § 488 (1)(f). Allegation 2 of the substantiated report will not be amended or sealed.

Because the Justice Center substantiated the allegation of abuse (obstruction of reports of reportable incidents) as a Category 1 act, which is the most serious category determination, the question becomes whether the elements as set out in SSL § 493(4)(a)(xiii) are also met. In this case, the Justice Center had to establish that the Subject intentionally made a materially false statement during an investigation into a report of a serious conduct of physical abuse and/or neglect of the Service Recipient as described in SSL § 493(4)(a)(i) and § 493(4)(a)(ii), with the intent to obstruct such investigation.

Serious physical abuse under SSL § 493(4)(a)(i) includes "intentionally causing physical injury as defined in "Penal Law § 10.00(9) or "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..." New York Penal Law § 10.00(9) defines physical injury as an "... impairment of physical condition or substantial pain..."

Serious conduct of neglect under SSL § 493(4)(a)(ii) includes a knowing, reckless or criminally negligent failure to perform a duty that resulted in physical injury that created a substantial risk of death or caused death.

In her defense, the Subject argued that the Category 1 level threshold in Allegation 1 of the report cannot be reached because at the time of the investigation the Subject had not yet received the substantiated report and could not have been aware at the time that said investigation involved Category 1 serious conduct. However, the Subject's argument lacks merit because SSL § 493(4)(a)(xiii) requires only that the intentional, materially false statements be made during an "investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph..." and because the Subject's argument would require the Subject to be unaware of her own conduct.

In this case, the Subject's intentional conduct, falsely reporting the position of the Service Recipient during a seizure, contributed to the overall failure to ensure that proper medical attention was given to the Service Recipient. Although the Subject was not an eyewitness to the physical abuse by Staff 1 of the Service Recipient, she admitted that she was aware that the Service Recipient was having a seizure when she momentarily entered to room. The Subject thereafter participated in and contributed to the collective false story by alleging that the Service Recipient was turned on his recovery side during the seizure. The Subject facilitated what Service Recipient C described as a history of staff conferring with each other about what to write in their incident reports and statements. The Subject supported and promoted the perpetuation of the false scenario that was reported to medical professionals, facility supervisors and Justice Center Investigators.

The ensuing investigation, during which the Subject intentionally made materially false statements, was plainly an investigation into a report of conduct described as serious physical abuse and serious neglect. (SSL § 493(4)(a)(i) and § 493(4)(a)(ii))

As set forth above, the investigation was into the circumstances and potential culpability surrounding the clear traumatic injuries sustained by the Service Recipient which triggered a post-traumatic grand mal seizure with loss of consciousness for at least fifteen minutes, with an accompanying significant time lapse in obtaining vital and necessary medical attention.

Certainly, the investigation was into a report of conduct described as serious physical abuse and serious neglect as to how the Service Recipient sustained a post-traumatic seizure and languished without medical attention for far too long. In the context of that investigatory interview, the Subject intentionally made the materially false statements with the intent to obstruct the investigation motivated by her desire to protect her employment. The record established that the Subject, during investigation, colluded and conspired with Co-Subjects (excluding Staff 5) in the perpetuation and continuation of a false narrative to impede the investigation and conceal their conduct.

Accordingly, the Subject's intentional and materially false statements during an investigation into a report of serious conduct of physical abuse and neglect was made with the intention to obstruct such an investigation. A substantiated Category 1 finding of abuse will result in the Subject being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 1 report will be disclosed to entities authorized to make inquiry to the VPCR. Substantiation of a Category 1 offense permanently places the Subject on the Staff Exclusion List.

Allegation 3 - Category 1 neglect

The Justice Center did not prove by a preponderance of the evidence that the Subject committed neglect by failing to provide adequate medical care to the Service Recipient, which included not immediately seeking medical attention and/or making appropriate notifications for him while he experienced a grand mal seizure, not appropriately positioning him during his seizure episode, and/or not immediately complying with requests made by the Emergency Medical Technicians.

In order to sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that her breach either 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 Recipient. (SSL § 488(1)(h))

At the hearing, the Subject testified consistently with her investigatory interview. She testified that she had initially responded to the [REDACTED] and stepped inside the Computer Room only for a few seconds in order to ask staff if they needed additional assistance. At that time, staff present in the room who were handling the emergency told her to go across the hall to assist the other service recipients and she immediately left the room. The Subject testified that she returned to the Computer Room to assist medical staff. The Subject testified that while holding down the Service Recipient's legs she saw foam in the Service Recipient's mouth and the facility physician was trying to administer an IV into the Service Recipient's arm. (Hearing testimony of the Subject)

After carefully reviewing the credible evidence, the record does not sufficiently show a breach of duty on the Subject's part. The Subject only had a brief initial presence in the room, at which time staff who were already handling the Service Recipient's emergency told her to go

across the hall to assist the other service recipients.

The record established that at the time the Service Recipient was taken down to the floor, the Subject was not in the room during the altercation and had no reason to believe, suspect or even hear that the Service Recipient had sustained a head injury triggering her duty under the Head Injury Policy to immediately contact the nurse. The Subject's non-presence in the room at the time of the altercation is corroborated by Staff 8's and the Co-Subjects' accounts of the incident. (Justice Center Exhibit 67) As such, the Subject did not breach her duty to the Service Recipient by failing to provide immediate medical attention/ notifications.

The record further does not sufficiently establish that the Subject breached her duty in failing to appropriately position the Service Recipient during his seizure because when the Subject came back into the Computer Room a second time, medical staff were present, and she acted under their direction to assist them. Staff 8's and Staff 7's accounts of the incident corroborate that the Subject had returned and was present in the room assisting in holding down the Service Recipient so that medical staff could try to administer his IV. Given this, it is further found that the Subject did not commit neglect by not immediately complying with requests made by the EMTs to release the Service Recipient. The EMTs could not identify the staff whom the requests were made to nor was there proof in the record to show that the Subject failed to comply.

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged in Allegation 3 of the report. As to Allegation 3, the substantiated report will be amended or sealed.

Since the report as to Allegation 3 will be unsubstantiated, it is not necessary to discuss whether the substantiated report constitutes the category of neglect set forth in the substantiated report under SSL § 493(4)(a)(ii).

DECISION:

The request of [REDACTED] that the substantiated report dated [REDACTED], [REDACTED] be amended and sealed shall be as follows:

As to Allegation 1, the said substantiated report shall be unsubstantiated, amended and sealed in that the Subject has not been shown by a preponderance of the evidence to have committed Category 2 abuse (obstruction of reports of reportable incidents);

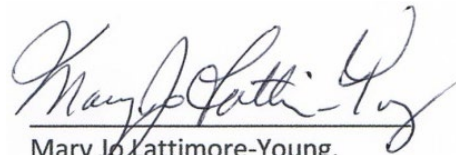
As to Allegation 2, the said substantiated report shall not be amended and sealed in that the Subject has been shown by a preponderance of the evidence to have committed Category 1 serious conduct of abuse (obstruction of reports of reportable incidents).

As to Allegation 3, the said substantiated report shall be unsubstantiated, amended and sealed in that the Subject has not been shown by a preponderance of the evidence to have committed Category 1 neglect.

The substantiated report is properly categorized as a Category 1 act.

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

DATED: December 4, 2019



Mary Jo Lattimore-Young,
Administrative Law Judge