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

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

[redacted]
By: Ramses Delva, Esq.
193-05 Hillside Avenue
Hollis, New York 11423

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

The substantiated reports are properly categorized as Category 2 acts.

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

[redacted]

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

DATED: Schenectady, New York
April 3, 2015

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

ADJUDICATION CASE [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

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

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
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[redacted]

JURISDICTION

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

FINDINGS OF FACT

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

1. The VPCR contains a "substantiated" report dated [redacted], [redacted], dated [redacted] of abuse and/or neglect by the Subject against a Service Recipient.

2. The Justice Center substantiated the report against the Subject for abuse and/or neglect. The Justice Center concluded that:

Offense 1

It was alleged that on [redacted], in Room [redacted] of the [redacted], located at [redacted], while acting as a custodian (Patient Care Aide), you committed an act of physical abuse and/or abuse (deliberate inappropriate use of restraints) when you tied a service recipient to his hospital bed, covered him with a sheet, and left his hospital room.

This offense has been SUBSTANTIATED as a Category 2 offense pursuant to Social Services Law § 493.

Offense 2

It was alleged that on [redacted], in Room [redacted] of the [redacted], located at [redacted], while acting as a custodian (Patient Care Aide), you committed neglect when you tied a service recipient to his hospital bed, covered him with a sheet, and left his hospital room.

[redacted]

This offense has been SUBSTANTIATED as a Category 2 offense pursuant to Social Services Law § 493.

3. The Service Recipient resides in a small residential [redacted], operated 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. (Justice Center Exhibit 6)

4. At the time of the incident, the Service Recipient was a patient in Room [redacted] of the [redacted], located at [redacted]. The Service Recipient was temporarily hospitalized to treat a urinary tract infection but, during his hospitalization, he remained a resident of the OPWDD facility. (Justice Center Exhibit 6)

5. At the time of the incident, the Service Recipient was 63 years. He was a person with a diagnosis of profound mental retardation and was completely dependent on staff for all of his daily needs. He was non-ambulatory and non-verbal. His target behaviors included removing his clothing, smearing his feces, property destruction and pulling out his feeding tube. (Justice Center Exhibit 20)

6. At the time of the incident, [redacted], a private agency, had a contract with OPWDD to provide a 1:1 Aide/Sitter for the Service Recipient, during the Service Recipient's period of hospitalization. The Subject, who had been employed by [redacted], for approximately one year, was assigned as the Aide/Sitter for the Service Recipient from 8:00 a.m. until 8:00 p.m. on [redacted]. (Justice Center Exhibit 6)

7. At approximately 1:30 p.m. on [redacted], The Subject, who had been providing 1:1 care to the Service Recipient, tied the Service Recipient's left hand to his bed-rail

[redacted]

and then spoke to one of the nursing staff to indicate his wish to take a lunch break. He then left the room for his break. (Justice Center Exhibit 6)

8. Shortly thereafter, two OPWDD employees, who had been sent to the hospital to arrange for the Service Recipient's discharge and transportation back to the OPWDD residence, entered the hospital room. They found the Service Recipient alone in the room, asleep in the bed and his left hand was tied to the bed-rail by a twisted disposable blue bed pad. They contacted hospital staff, who soon thereafter attended, and the Service Recipient's hand was untied. (Justice Center Exhibit 6)

9. When the Subject returned to the hospital room, approximately one half hour after having left it, he found the two OPWDD aides and some hospital staff members in the room with the Service Recipient. The Subject was confronted by Director of Patient Care, [redacted], and he gestured that he had tied the Service Recipient's hand to the bed-rail to prevent him from pulling out his hospital tubes. (Justice Center Exhibit 6)

10. The Subject was dismissed from his assignment early, at approximately 2:00 p.m. The OPWDD aides supervised the Service Recipient for the rest of the afternoon, until another OPWDD aide arrived. (Justice Center Exhibit 6)

11. Because there was some redness to his wrist, the treating physician postponed the Service Recipient's discharge by one day and the Service Recipient remained in the hospital overnight for x-rays and observation. The x-rays subsequently revealed that the only injury to the Service Recipient was a skin abrasion where the pad had been wrapped around his wrist. (Testimony of [redacted])

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.

[redacted]

- 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/or neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse and/or neglect; and pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488:

1. "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:

    (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment.

[redacted]

Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

(b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

(c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations.

Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

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

[redacted]

> provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(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).

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493:

> 4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:
>
> (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:
>
> (i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;
>
> (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;
>
> (iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

[redacted]

(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

[redacted]

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.

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

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged 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 evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject

[redacted]

committed the abuse and neglect as alleged in the Report of Substantiated Finding. Specifically, the evidence establishes that, with respect to Offense 1, the Subject committed an act of abuse by employing a deliberate inappropriate use of restraints, when he tied the Service Recipient to the hospital bed-rail. The category of the affirmed substantiated abuse that such act constitutes was properly substantiated as a Category 2 act.

The evidence further establishes that, with respect to Offense 2, the Subject committed an act of neglect when he tied the Service Recipient to his hospital bed and left the Service Recipient alone in his hospital room. The category of the affirmed substantiated neglect that such act constitutes was properly substantiated as a Category 2 act.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-21) The investigation underlying the substantiated report was conducted by OPWDD Internal Investigator, [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center. The Subject testified on his own behalf and provided no other evidence.

With respect to Offense 1 of the Report of Substantiated Finding, it is clear that the tying of the Service Recipient's hand to the hospital bed-rail fits squarely within the definition of a deliberate inappropriate use of restraints as set out in SSL § 488(1)(d). It was the "*use of a restraint... [that]... is deliberately inconsistent with [the] service recipient's... behavioral intervention plan... and... generally accepted treatment practices...*" The definition of deliberate inappropriate use of restraints specifies the use of *"... any mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body*." The only exception to the prohibition against the use of deliberate inappropriate use of restraints is "*... when the restraint is used as a reasonable emergency intervention to prevent*

[redacted]

imminent risk of harm to a person receiving services or to any other person." SSL § 488(1)(d)

The Service Recipient's *Behavior Plan* is a five page document that details the Service Recipient's "target behaviors" and the recommended ways to deal with them. Under *Restrictive Interventions*, the only "*Rights limitations*" prescribed is the use of a "*jumpsuit*" to prevent stripping, fecal smearing and the pulling out of his feeding tube. Nowhere in the *Behavior Plan* is there any provision for the use of any physical restraints. Beside the subheading of; *Strategies for Crisis Intervention and Prevention (SCIP)*, the restrictive interventions listed are "*none*." (Justice Center Exhibit 20)

The Justice Center submitted a significant number of documents detailing the training and policies that reflect generally accepted treatment practices. (Justice Center Exhibits 9, 10, 11, 12, 16, 17 and 18)

These Exhibits unequivocally establish that tying a Service Recipient to his bed is not only prohibited, but, it is also a flagrant violation of the principles of the "Person-Centered Approach" to caregiving, most succinctly set out in the *Code of Conduct for Custodians of People with Special Needs,* a copy of which the Subject had signed on [redacted]. (Justice Center Exhibit17)

The Subject's defense was twofold. Firstly, his testimony was that he did not tie the Service Recipient to his bed, but only wrapped his hand in a blue hospital bed pad, to stop him from soiling his hand and then putting it into his mouth, thereby harming himself. Secondly, the Subject's testimony was, essentially, that his lack of fluency in English prevented him from being familiar with the training and policy materials that he received, some of which, he signed for. (Testimony of [redacted]; Subject)

Hearsay is admissible in administrative proceedings and an administrative determination

[redacted]

may be based solely upon hearsay evidence under appropriate circumstances. Gray v. Adduci, 73 N.Y.2d 741 (1988), 300 Gramatan Avenue Associates v. State Division of Human Rights, 45 N.Y.2d 176 (1978), Eagle v. Patterson, 57 N.Y.2d 831 (1982), People ex rel Vega v. Smith, 66 N.Y.2d 130 (1985). A crucial concern with respect to hearsay evidence is the inability to cross-examine the person who originally made the statement in order to evaluate his or her credibility. Such evidence, then, must be carefully scrutinized and weight attributed to it would depend upon its degree of apparent reliability. Factors to be considered in evaluating the reliability of hearsay include the circumstances under which the statements were initially made, information bearing upon the credibility of the person who made the statement and his or her motive to fabricate, and the consistency and degree of inherent believability of the statements. The Subject's hearing testimony, that he did not utilize this mechanism of restraint, is not credited evidence, especially as it conflicts so strongly with the statements of the disinterested eyewitnesses.

There are two signed statements from the OPWDD aides, who had been sent, on [redacted], to manage the discharge from hospital and transportation of the Service Recipient back to the facility. Both of the aides state that they clearly saw the Service Recipient tied to the bed-rail upon their arrival in his room. (Justice Center Exhibits 7, 8)

One of the aides told [redacted] that when she and the other aide entered the Service Recipient's hospital room, "... she observed his left hand tied to the bed-rail with a blue (chuck) pad at the wrist area." Upon this discovery, the aides made the appropriate notifications and when the nurse came into the room and removed the pad, the aide "... noticed that the individual had a red ring around his wrist area." She described that, "... the blue chuck pad appeared to have been 'twisted' like a rope to tie his hand and 'tied tight to not unravel.'" (Justice Center

[redacted]

Exhibit 6)

Furthermore, [redacted] Director of Patient Care Services, [redacted], advised [redacted] that, when she arrived at the Service Recipient's hospital room, she asked the Subject what had happened and that The Subject;

> ... gestured and described that the patient was agitated and was trying to pull his (hospital) tubes out from him. [redacted] stated the Subject stated that, "I put his (patient's) hand like that." [redacted] stated that the Subject was gesturing how he tied the patient's hand/arm to the bed-rail to stop the patient's behavior... [redacted] stated she learned that the hospital nursing assistant had been in the patient's room 15 minutes prior to the Subject's departure for his break (1:30), preparing the patient for discharge that day and that the patient was not tied to the bed-rail with the blue pad... (Justice Center Exhibit 6)

Accordingly, based on all of the evidence, it is found that the Subject did tie the Service Recipient's hand to the hospital bed-rail, thereby employing a deliberate inappropriate use of restraints.

The evidence is that the Subject indicated to [redacted], at the time, that his actions were necessary to prevent the agitated Service Recipient from pulling out his feeding tube or other tubing. (Justice Center Exhibit 6)

[redacted] Investigative Report provides the Subject's subsequent statements to him that;

> ... at approximately 11:00 a.m., the patient became agitated and placed his fingers in his anus area and then into his mouth. The Subject stated that the patient was nonverbal and could not express his needs/wants. He stated that he tried to redirect the patient, however, was unsuccessful. He stated that he called for the nurse for assistance via the call button on the patient's bed. The Subject stated that the nurse arrived at the room approximately at 12:00 p.m., approximately 1 hour after he had summoned the nurse. He stated that he assisted the nurse with cleaning and the changing of the individual. The Subject stated that immediately thereafter the patient again became agitated, exhibiting the same behavior as noted above. (Justice Center Exhibit 6)

The Subject testified that the Service Recipient was putting his left hand down the back

[redacted]

of his diaper and then into his mouth. The Subject's testimony that the Service Recipient was agitated and exhibiting self-harming behavior and that the nursing staff was slow to respond, was consistent with his statements to [redacted]. (Testimony of [redacted]; Subject)

The implication from all three renditions of the Subject's version of events is that his actions were necessary to prevent the Service Recipient from continuing with his self-harming behaviors. Although the described behaviors were certainly detrimental to the Service Recipient's well-being and health, they did not rise to the threshold of "imminent risk of harm" as specified in SSL § 488(1)(d), and, therefore, did not qualify as an exception to the prohibition against the deliberate inappropriate use of restraints as they were employed by the Subject.

The Subject's secondary argument was that his lack of fluency in the English language prevented him from understanding the contents of the extensive training and policy materials. These exhibits, provided by the Justice Center, were proffered to establish that the Subject should have known that Service Recipients cannot be tied to their beds and left alone. (Justice Center Exhibits 9, 10, 11, 12, 16, 17 and 18)

The Subject's English language barrier argument was offered at the hearing in a general way to counter both findings of abuse and neglect. Although the Subject had signed the *Sitter Job Description* (Justice Center Exhibit 10), the [redacted] *Patient Care Aide Training Manual* (Justice Center Exhibit 11) and the *Code of Conduct for Custodians of People with Special Needs* (Justice Center Exhibit 17), he testified that he was unaware of their contents as he cannot understand the English language well enough to be able to read them. In fact, upon cross examination, the Subject denied knowing what was in any of the training and policy documents that were entered as exhibits in this matter, indicating that no one ever interpreted them for him. (Testimony of [redacted]; Subject)

[redacted]

However, in his testimony, the Subject acknowledged that he had attended a four week training as a Home Health Care Aide in [redacted]. This program was presented in English, but was translated into Creole by the teacher's assistant for the benefit of some of the students, including the Subject. (Testimony of [redacted]; Subject)

The Subject received a Certificate of Completion that, as of [redacted], he was qualified as a Home Health Aide under a program approved by the New York State Education Department. (Justice Center Exhibit 15)

The *In-Hospital Sitter Reporting Form* is a document that [redacted] requires its employees to complete for each assignment. The *In-Hospital Sitter Reporting Form,* dated [redacted] (Justice Center Exhibit 13), was completed by the Subject in English. During his cross examination, the Subject's explanation for his ability to answer the questions which were written in English was simply that "someone" had told him how to fill it out. (Testimony of [redacted]; Subject)

The affidavit of [redacted], Executive Director of [redacted], was strong evidence regarding The Subject's English language fluency and the extent of his training. It indicates that:

> [a]t the time [redacted] became employed by [redacted] he was already certified as a Home Health Aide by the New York School of Health and Business Careers. He was also registered as a Home Care Worker with the New York State Home Care Registry. It is our understanding that to receive these credentials, [redacted] was fully trained in how to perform his job responsibilities as a health aide, hospital sitter/companion.
>
> Like all [redacted] sitter/companions, [redacted] was provided significant training, including written materials, to assist him in completing his job duties and responsibilities. In order for a sitter/companion to be hired by [redacted], the company ensures that the prospective employee understands the job responsibilities and has a competent understanding of the English language.
>
> [redacted] does not require English to be a sitter/companion's primary

[redacted]

> language, but the prospective employee must be able to have sufficient control of English to be able to understand their job responsibilities and be able to sufficiently communicate with the patient..... [redacted] was provided a detailed handbook... [n]otably, page 4 of our training manual lists the use of medical restraints as a form of abuse... [(Justice Center Exhibit 9)]
>
> Contrary to [redacted] statements to the Justice Center, he was not simply provided this document by mail and asked to sign it. [redacted] trains each sitter/companion individually, reviewing the job responsibilities and what they are and are not permitted to do with respect to each patient. Once [redacted] is confident that the employee understands the material and their job responsibilities, the employee is asked to sign and acknowledge that they received the material and understand what is expected of them. (Justice Center Exhibit 21)

The Subject testified that [redacted], "knew that he could not read English but didn't say anything about it. The Subject testified further that his sister-in-law, an employee of [redacted], was "the one [he] called to get jobs." Furthermore, the Subject testified that he got his job without an interview because of his sister-in-law's position. (Testimony of [redacted]; Subject)

English is not the Subject's first language and an Interpreter was utilized to translate for the hearing in this matter for the Subject. However, the uncontradicted evidence in the record is that the Subject clearly received training, at least some of which was translated into his native language. Additionally, the Subject signed and completed several acknowledgements pertaining to understanding the relevant policies and trainings. After considering all of the evidence, there is no merit to the Subject's language barrier argument.

With respect to Offense 2 of the Report of Substantiated Finding, that the Subject committed an act of neglect, by leaving the Service Recipient unsupervised in his hospital room, the Subject testified that he had followed appropriate procedure of requesting that a member of the hospital staff cover for him when he needed a break. (Testimony of [redacted]; Subject)

The Subject's testimony was that at approximately 1:35 p.m., he asked a nursing

assistant, who was in the hallway, to cover for him while he took a break. She responded affirmatively and the Subject then immediately left the room without waiting for the nursing assistant to come into the room. (Testimony of ; Subject)

This conversation was corroborated by the evidence obtained by investigation. However, even though the Subject had correctly sought alternate supervision of the Service Recipient while he took his break, he failed to wait for the promised supervision to materialize and improperly left the Service Recipient alone.

Once again, the extensive training/policy material makes clear that custodians assigned as Sitters are not to leave the Service Recipient unsupervised. The *Patient Care Aide Training Manual* (Justice Center Exhibit 11), signed by the Subject, states, under the heading, Specific Instructions, that *(a) Sitter is to remain attentive to the patient at all times until relieved by hospital personnel* and it states under *(e) Sitters are not to leave their patient unattended.*

It is found that the Subject's act of leaving the Service Recipient alone in his hospital room, even though a nursing assistant had told him that she would cover for him, constitutes neglect. The Subject breached his duty as a custodian, when he left the room before a replacement had come in to supervise the Service Recipient in his absence. The Service Recipient was completely helpless, unable to communicate and totally dependent on his caregivers to ensure his safety and comfort. The Subject's breach of duty was, "likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition," of the Service Recipient, as set out in SSL § 488(1)(h).

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report**.** It is hereby determined, that both the abuse and neglect are properly

[redacted]

categorized as Category 2 acts.

Category 2 conduct under this paragraph shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that such custodian engaged in Category 2 conduct. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

In the final analysis, based on all of the evidence, it is concluded the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the abuse as alleged in "Offense 1" and the neglect as alleged in "Offense 2"of the substantiated report. The abuse and the neglect shall remain Category 2.

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

The substantiated reports are properly categorized as Category 2 acts.

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

DATED: March 18, 2015
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge