

**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]
[REDACTED]
[REDACTED]

██████████

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

ORDERED: The request of ██████████ that the report substantiated on ██████████
██ dated and received on ██████████
██████████ be amended and sealed is denied. Although the Subject has not
been shown by a preponderance of the evidence to have committed
neglect by failing to call 911, the Subject has been shown by a
preponderance of the evidence to have committed neglect by failing to
prepare the Service Recipient's food in accordance with the Facility
choking protocol and the Service Recipient's meal protocol as alleged in
Offense 1.

The substantiated report is properly categorized as a Category 2.

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

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: October 2, 2015
Schenectady, New York



David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjud. Case #:

[REDACTED]

Before:

John T. Nasci
Administrative Law Judge

Held at:

West Seneca DDSO
1200 East and West Road
Building 16
West Seneca, NY 14224
On: [REDACTED]

Parties:

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

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

[REDACTED]
[REDACTED]
[REDACTED]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for abuse and/or 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 report substantiated on [REDACTED], dated and received on [REDACTED] of neglect by the Subject of a Service Recipient.

2. On or about [REDACTED], the Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Offense 1

It was alleged that on [REDACTED], on an outing from [REDACTED] to a local restaurant located at [REDACTED], while acting as a custodian, you committed neglect when you failed to follow a service recipient's IPOP and/or meal time protocol, resulting in the service recipient choking, and failed to follow the agency's choking protocol by failing to call 911 after the Heimlich maneuver was used to dislodge food from the service recipient's throat¹.

These allegations have been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493.

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

¹ At the hearing, the Justice Center put forth two distinct factual allegations to support this one theory of Substantiation. The factual allegations were offered separately under the theory that individually either could support the Substantiated conclusion.

_____)

immediately preceding the date of the incident on [REDACTED]

Justice Center Exhibit 16 and Justice Center Exhibit 17)

[audio interview of Staff [REDACTED] and testimony of the Subject)

8. The Subject and Staff [REDACTED] ordered food for themselves and the two service recipients and then sat down at a table with a fixed booth-style seat on one side and two non-fixed chairs on the other. One end of the table abutted a wall and the other end was open. Staff

█████ sat on the inside of the booth seat with her service recipient sitting next to her on the outside booth seat. The Subject sat across from Staff █████ with the Service Recipient sitting next to her in her wheelchair across from the other Service Recipient. (See Justice Center Exhibit 24 [audio interview of Staff █████]; and testimony of the Subject)

9. After sitting down, the Subject started cutting the Service Recipient's hotdog perpendicularly to the length of the hotdog. The Service Recipient then grabbed a piece of cut hotdog that was approximately one and one half inches in length, put it in her mouth and tried to swallow it. The Service Recipient immediately started choking. In response to the Service Recipient's choking, the Subject stood up, went behind the Service Recipient's wheelchair and attempted to perform the Heimlich maneuver. Because Staff [REDACTED] was on the inside of the booth seat, she was not able to get up in time to help the Subject. Another patron of the restaurant who was sitting nearby saw that the Subject was unable to properly perform the Heimlich maneuver, told the Subject she was a registered nurse, took over for the Subject and was able to dislodge the piece of hotdog from the Service Recipient's throat using the Heimlich maneuver. (See Justice Center Exhibit 24 [audio interview of Staff [REDACTED]]; and testimony of the Subject)

10. After the piece of hotdog was dislodged from the Service Recipient's throat, the Service recipient resumed her normal affect. The Subject then called her supervisor who instructed the Subject to return with Staff [REDACTED] and the two service recipients to the Facility. Once at the Facility, the Subject called the on-call Nurse who instructed the Subject to send the Service Recipient to the ER or a nearby MASH unit to make sure the Service Recipient's throat was clear of objects, which the Subject did. (See Justice Center Exhibit 24 [audio interview of Staff [REDACTED]]; Justice Center Exhibit 20; testimony of [REDACTED]; and testimony of the Subject)

11. The Service Recipient suffered no lasting or long term effects of the [REDACTED]

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choking incident. (See Justice Center Exhibits 21, 22 and 23)

12. The Subject was trained on the CPI on ██████████ (Choking Initiative Part 1) and on ██████████ (Choking Initiative Part 2). The Subject was fully aware of the Facility's choking policies and protocols, and the Service Recipient's mealtime protocol. (See Justice Center Exhibit 8 and testimony of the Subject)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

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

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

"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 Category 2 neglect, which is defined as follows:

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

If the Justice Center proves the alleged abuse and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

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

DISCUSSION

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The Justice Center has established by a preponderance of the evidence that the Subject committed a prohibited act described in the substantiated report as Offense 1. The evidence established that the Subject failed to follow Facility CPI protocol and the Service Recipient's meal protocol which resulted in the Service Recipient choking on food. The Justice Center has not sufficiently established that the Subject committed a prohibited act by failing to follow Facility emergency medical protocol.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation (Justice Center Exhibits 1-23 and 25), and audio recordings of the Justice Center investigator interrogations (Justice Center Exhibit 24). The investigation underlying the substantiated report was conducted by Justice Center Investigator, ██████████, who testified at the hearing on behalf of the Justice Center. The Justice Center presented one other witness, ██████████. The Subject presented six documents (Subject Exhibits 1-6) and testified on her own behalf.

Theory I: Subject's Failure to Follow CPI and Meal Protocol

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect by failing to follow Facility CPI protocol and by failing to follow the Service Recipient's specific meal protocol.

The facts are generally not in dispute. The record reflects that the Subject was a custodian of the Service Recipient by virtue of her employment with the ██████████ at the Facility.

The record further reflects that the Service Recipient's meal protocol that was in effect at the time of the incident on ██████████ required that all meats be ground. The meal protocol also notes the following: "Be alert for attempts by ██████████ to take food from others ..." (See

Justice Center Exhibit 19) Also contained in the record and not in dispute is the OPWDD Choking Prevention Initiative (CPI) which is the protocol used by [REDACTED], regarding food consumption by Service Recipients. The CPI defines ground food as food processed in a “food processor or comparable equipment” and being “MOIST, COHESIVE AND NO LARGER THAN A GRAIN OF RICE” (emphasis from original). (See Justice Center Exhibit 7 page 26) The pertinent CPI guidelines for hotdogs are as follows: 1) skinless hotdogs are highly recommended; 2) all hotdogs must be cut lengthwise; and 3) “adequate supervision of individuals must occur when hotdogs/sausages are served.” (See Justice Center Exhibit 7 page 10)

The record reflects that although the Subject was fully trained in the CPI and meal protocols, she ignored the protocols and prepared food for the Service Recipient in a manner that was inconsistent with the Facility policies and inconsistent with the specific meal protocol of the Service Recipient. The record further reflects that the Subject’s failure to prepare the Service Recipient’s food properly resulted in the Service Recipient choking on the food and requiring emergency medical intervention to remove the food that was lodged in the Service Recipient’s throat.

Although there is no evidence in the record that the Service Recipient suffered any lasting or long term physical harm, the Subject’s failure to follow Facility food preparation protocol resulted in the Service Recipient choking which could have likely resulted in physical injury to the Service Recipient.

Consequently, the Justice Center has sufficiently established that the Subject committed neglect by failing to follow Facility protocol and the Service Recipient’s meal protocol.

Theory II: Subject’s Failure to Call 911

The Justice Center also alleged that the Subject committed neglect by failing to follow

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the Facility's choking protocol by failing to call 911 after the Heimlich maneuver was used to dislodge food from the Service Recipient's throat.

The record reflects that the Facility Emergency Medical Policy and Procedure required that the Subject "activate Emergency Medical Services (911) *immediately*, if indicated" (capitalization and emphasis from original) (See Justice Center Exhibit 6), and that the Service Recipient's ██████████, choking incident was a medical emergency that required such activation of emergency medical services. (See testimony of ██████████) The record further reflects that the Subject did not call 911 or otherwise activate emergency medical services as a result of the Service Recipient choking on ██████████.

However, the Subject's uncontested testimony established that she was not trained in the Facility's Emergency Medical Policy and that the first time she had seen the Facility's policy was when she received it from the Justice Center attorney as a proposed Justice Center exhibit in this proceeding. (See testimony of the Subject) The Justice Center presented no evidence of any training the Subject received concerning the Facility's emergency procedures, or that the Subject was otherwise taught or told what to do in an emergency situation. Furthermore, there is no evidence in the record that would lead to a finding that the Subject's testimony should not be given full credit. Consequently, the Subject cannot be found to have failed to follow the Facility's emergency protocol in the absence of evidence in the record establishing that she had knowledge of such protocol. Likewise, the Subject cannot be found to have breached a duty that she has not been proven to have acquired.

Therefore, the Justice Center has not sufficiently established that the Subject has committed neglect by failing to call 911 and follow Facility emergency protocols.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the alleged neglect under the theory

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that the Subject failed to follow the Facility CPI and the Service Recipient's meal protocol. The Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the alleged neglect under the theory that the Subject failed to call 911 in contravention of the Facility's emergency medical protocol. Consequently, the substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence, the testimony presented and the governing legislation, it is determined that the category of the affirmed substantiated neglect described as Offense 1 in the substantiated report was properly substantiated as a Category 2 act. Category 2 conduct 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.


DECISION:

The request of ██████████ that the report substantiated on ██████████
██████████; dated and received on ██████████
██████████ be amended and sealed is denied. Although the Subject has not been shown by a preponderance of the evidence to have committed neglect by failing to call 911, the Subject has been shown by a preponderance of the evidence to have committed neglect by failing to prepare the Service Recipient's food in accordance with the Facility choking protocol and the Service Recipient's meal protocol as alleged in Offense 1.

The substantiated report is properly categorized as a Category 2.

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

DATED: September 1, 2015
Schenectady, New York



John T. Nasci, ALJ