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: Theresa Wells, Esq.

[redacted]

By: Nicole Murphy, Esq.
Fine, Olin and Anderman, LLP
39 Broadway, Suite 1910
New York, New York 10006

[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 report substantiated on [redacted], [redacted] dated and received on [redacted] be unsubstantiated is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

Allegation 1 of the substantiated report is properly categorized as a Category 3 act.

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

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

DATED: Schenectady, New York
November 17, 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 West 125th Street
New York, New York 10027
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
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[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], [redacted] dated and received on [redacted] of abuse and/or 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], MDU [redacted] Wing, Building [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide adequate supervision to a service recipient, during which time she swallowed two staples.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect, pursuant to Social Services Law § 493(4)(c).

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

4. The facility, the [redacted], located at [redacted], is a secure residential [redacted] for adults and children with developmental disabilities and psychiatric diagnoses

[redacted]

and is 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.

5. At the time of the alleged neglect, the Subject, [redacted], who had been employed at the facility as a Direct Support Assistant (DSA) for approximately twenty-two years, was working her regular shift from [redacted] in the [redacted] Wing of Building [redacted] of the Multiple Diagnoses Unit (MDU) of the facility. The Subject was assigned to provide 1:1 supervision to the Service Recipient. (Hearing testimony of the Subject and Justice Center Exhibit 6)

6. At the time of the alleged neglect, the Service Recipient was a twenty-seven year old resident of the [redacted] Wing of Building [redacted] of the facility's MDU and had been residing at the facility for ten years. The Service Recipient is a person with diagnoses of mild intellectual disability and behavioral issues, which include Pica, the desire to deliberately ingest inedible substances, as well as self-injurious conduct and making false allegations. Because of her behaviors, the Service Recipient is supervised on a 1:1 basis at all times. Additionally, there are hourly checks of the rooms that she uses to ensure that any objects that she may try to ingest are removed. There are numerous other safeguards that are also followed to protect the Service Recipient. (Justice Center Exhibit 19)

7. The Pica Sweep Checklist for Building [redacted] of the MDU [redacted] Wing shows that on [redacted], the rooms in the unit were checked every hour for small objects and that a sweep was performed at 10:00 p.m. by DSA [redacted]. (Justice Center Exhibit 7)

8. On [redacted], at approximately 10:45 p.m., during the Subject's 1:1 supervision of the Service Recipient in a facility common area that had been checked for objects,

[redacted]

the Service Recipient surreptitiously ingested one or two upholstery staples and immediately notified another staff member of what she had done. When the other staff member advised the Subject that the Service Recipient had swallowed something, the Subject immediately checked the Service Recipient's mouth for foreign objects and found nothing. (Hearing testimony of the Subject)

9. On [redacted], as the Subject was leaving for the night at approximately 11:25 p.m., Developmental Assistant 1 (DA1) [redacted] overheard the Subject mumbling to herself about the Service Recipient having swallowed staples. DA1 [redacted] followed the Subject and questioned her regarding the matter. The Subject then told DA1 [redacted] that the Service Recipient claimed to have ingested two staples earlier. DA1 [redacted] instructed the Subject to complete an OPWDD Reporting Form 147 and to take the Service Recipient to the nurse on duty. (Justice Center Exhibit 4)

10. On [redacted], at approximately 11:40 p.m., the Subject notified facility Registered Nurse (RN) [redacted] that the Service Recipient had ingested something earlier and she also provided RN [redacted] with the completed Form 147. RN [redacted] went to the Service Recipient, who advised RN [redacted] that she had swallowed two staples. RN [redacted] noted that, at that time, the Service Recipient exhibited no symptoms and appeared to be fine. The Service Recipient was then seen by Medical Specialist [redacted], who ordered that the Service Recipient be transferred to [redacted] Medical Center's Emergency Room for evaluation although he also noted that the Service Recipient had no complaints of discomfort. (Justice Center Exhibits 4, 14 and 15)

11. On [redacted], at approximately 12:35 a.m., before the Service Recipient had been transported to the hospital, she suddenly became extremely agitated and complained of

[redacted]

pain. Emergency Medical Services was called and the Service Recipient was taken to [redacted] Medical Center, where she was found to have a metallic foreign body present in her esophagus, consistent with her having ingested a staple. (Justice Center Exhibits 14 and 16)

12. It was later discovered that one of the couches in a common room where the Service Recipient had been while under the Subject's 1:1 supervision, had numerous upholstery staples on its underside as part of its construction and that two of the staples were missing from it. (Justice Center Exhibits 12 and 25)

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 allegation constitutes 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 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. Under SSL § 488(1)(h) neglect is defined as:

> "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical

[redacted]

> 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. Under SSL § 493 (4)(c), a Category 3 act is defined as:

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

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

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

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

[redacted]

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed the act described as Allegation 1 in the substantiated report. Specifically, the evidence establishes that the Subject committed an act of neglect under SSL § 488(1)(h) in that the Subject's inaction or lack of attention was a breach of her duty to the Service Recipient that resulted in physical injury to the Service Recipient.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-31) The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted], who was on leave at the time of the hearing. OPWDD Supervising Investigator [redacted] testified at the hearing on behalf of the Justice Center.

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

The Subject's answer to the allegation was twofold. Firstly, the Subject told OPWDD Investigator [redacted] on [redacted] and testified that, despite her own diligence, the Subject could not have observed the Service Recipient closely enough at that time to have prevented the Service Recipient from ingesting the staple(s). The Subject testified that the Service Recipient had become extremely upset by some bad news that she had heard. The Subject testified that the Service Recipient had fallen to the floor suddenly in an area of a common room that was crowded with furniture in such a manner that the Subject could not see the Service Recipient's face. The Service Recipient remained in that position for two minutes before getting up. (Hearing testimony of the Subject and Justice Center Exhibit 31)

Page one of Topic 5.1.11 of the [redacted] Policy and

[redacted]

Procedure Manual states that 1:1 supervision requires, among other things, that the staff member maintain visual contact with the service recipient. (Justice Center Exhibit 9)

Page one of the Service Recipient's Goal Plan Methodology with the effective date of [redacted], identifies the Service Recipient's Pica as the first Goal Area addressed in the Plan and contains six pages of analysis regarding the issue, including expected staff interventions and seventeen Rights Restrictions. (Justice Center Exhibit 19)

The Service Recipient's Behavior Plan/Human Rights Committee-Review, reviewed in [redacted], also contains the list of the seventeen Rights Restrictions imposed on the Service Recipient due to her Pica issues. (Justice Center Exhibit 18)

There are two OPWDD published Alerts that discuss the seriousness of the issue of Pica. (Justice Center Exhibits 29 and 30)

The Subject told OPWDD Investigator [redacted] on [redacted] and testified at the hearing that she was familiar with the Service Recipient's Pica behavior. The Subject denied in her testimony that she had received Pica training, but her training records establish that on [redacted], the Subject had completed Pica training. (Justice Center Exhibit 27)

The [redacted] Policy and Procedure Manual sets out the high standard of 1:1 supervision that the Subject was required to meet. The Goal Plan Methodology, the Behavior Plan/Human Rights Committee-Review and Rights Restrictions, the two OPWDD published Alerts establish the seriousness of maintaining the high standard of the 1:1 supervision. It was clear from all of the evidence that the Subject was alert to the Service Recipient's Pica issue.

It was not established exactly how the Service Recipient discovered and obtained the

staple(s) that she had ingested, but for the purpose of this analysis, it is not necessary. The important fact is that the Service Recipient somehow, while under the Subject's 1:1 supervision, was able to locate and ingest the staple(s). While providing 1:1 supervision of the Service Recipient may be challenging, that fact does not obviate the requirement of complete vigilance. The Subject failed to meet the high standard of supervision that was required of her and that failure was the breach of her duty to the Service Recipient. That breach of duty gave the Service Recipient the opportunity to swallow a foreign object, which resulted in injury to her.

Secondly, it was argued by the Subject's Counsel that it was not the Subject's fault that the Service Recipient swallowed the staple(s) because it was other staff members' responsibility to perform the hourly room "sweeps," which must have been done incompetently, as the Service Recipient found and ingested the staple(s).

While it is true that the room sweep protocol is a crucial safeguard to protect service recipients, it is only one of the many precautions that are instituted and is not a substitute for diligent 1:1 supervision, as this case so aptly demonstrates. Furthermore, it seems as if the staple(s) ingested might not have been found on the floor of the room, but rather, may have been pulled out from the underside of the couch by the Service Recipient, undetected by the Subject, which leads the analysis back to the Subject's breach of duty to vigilantly supervise the Service Recipient.

Accordingly, in the final analysis, based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect as specified in Allegation 1 of the substantiated report. The Subject's lack of attention to the Service Recipient, by failing to maintain visual contact, breached her custodial duty which resulted in physical injury to the Service Recipient.

[redacted]

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence and testimony presented, it is determined that the category of the affirmed substantiated neglect that such act constitutes was properly substantiated as a Category 3 act. A substantiated Category 3 finding of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496 (2). This report will be sealed after five years.

DECISION: The request of [redacted] that the report substantiated on [redacted], [redacted] dated and received on [redacted] be unsubstantiated is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

Allegation 1 of the substantiated report is properly categorized as a Category 3 act.

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

DATED: November 12, 2015
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge