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
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: Laurie Cummings, Esq.

[redacted]
By: Jason P. Jaros, Esq.
8207 Main Street, Suite 13
Williamsville, New York 14221

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

The substantiated report is properly categorized as a Category 3 act.

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: April 6, 2016
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: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People With Special Needs
1200 East and West Road
West Seneca, New York 14224
On: [redacted]

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

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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 "substantiated" report dated [redacted], [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:

Offense 1

> It was alleged that on [redacted], at the [redacted] Hospital, located at [redacted], while acting as a custodian, you committed neglect when you were less than alert and/or asleep while assigned to provide 1:1 arms-length supervision to a service recipient, during which time the service recipient removed his feeding tube.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law §493.

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

4. The facility, located at [redacted], is an [redacted] for developmentally disabled persons operated by the New York State Office for People With Developmental Disabilities (OPWDD) and is a facility

or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse and/or neglect, the Subject was employed by [redacted] as a Direct Support Assistant (DSA) for approximately nine years and was normally assigned to work a full-time shift from 3:00 p.m. to 11:00 p.m. at the [redacted]. However, on the date of the incident, the Subject was assigned to work an overtime shift from 6:00 a.m. to 2:00 p.m. and to provide one to one arms-length supervision of the Service Recipient, while he was hospitalized at [redacted] Hospital located in [redacted]. The Subject is a custodian of the Service Recipient by virtue of his employment at the [redacted].

6. At the time of the alleged abuse and/or neglect, the Service Recipient was forty-two years old, and had been a resident of the facility since approximately [redacted] 2004. The Service Recipient is a person with diagnoses of Obsessive Compulsive Disorder (OCD), PICA, Seizure Disorder, Self-Injurious Behavior (SIB), Osteoporosis and agitated behavior, which can lead to SIB and aggression. (Justice Center Exhibit 6, page 3)

7. During the Service Recipient's hospital stay on [redacted], it was required that a [redacted] OPWDD staff member provide one to one arms-length supervision of the Service Recipient. (Hearing testimony of the Subject and OPWDD Investigator [redacted]; Justice Center Exhibits 6 and 15)

8. Upon arriving at the hospital, the Subject was told by the [redacted] staff member, whom he was relieving, that the Service Recipient had to be closely supervised so as to prevent him from removing his nasal gastric feeding tube (NGT). (Hearing testimony of the Subject) When the Subject entered the Service Recipient's room, the Service Recipient was lying in his bed on his back with a ventilator attached to his trachea tube. (Justice Center Exhibit

10) The Subject sat in a chair on the left side of the Service Recipient's bed and within arms-length distance of him, in order to provide close supervision in case the Service Recipient tried to remove his NGT. (Hearing testimony of the Subject and Justice Center Exhibit 15) Despite the soft wrist restraints being attached to the bed frame and the hand mitts, it was known that the Service Recipient had repeatedly attempted to remove the NGT. (Hearing testimony of the Subject and OPWDD Investigator [redacted]; Justice Center Exhibits 6 and 10)

9. While working the 7:00 a.m. to 7:00 p.m. shift at the hospital, Registered Nurse 1 entered the Service Recipient's room on the morning of the incident to conduct an assessment. She introduced herself to the Subject and informed him that the Service Recipient has the ability to pull at his NGT.

10. Approximately one hour after Registered Nurse 1 had conducted her morning assessment, she re-entered the Service Recipient's room and saw that the Subject[1] had placed a pillow over the Service Recipient's left hand, which had a restraint on it and that the Subject was asleep with his head on the pillow. (Justice Center Exhibit 10, Justice Center Exhibit 11, page 2 and Justice Center Exhibit 12)

11. Throughout the Subject's shift, the Subject spent most of his time watching television and did not interact with or otherwise try to re-direct the Service Recipient from attempting to reach and remove his NGT. (Justice Center Exhibit 10, page 2)

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.

[1] It should be noted that when Registered Nurse 1 was interviewed by OPWDD Investigator [redacted], she did not know the name of the staff member who was supervising the Service Recipient on the morning of the incident. However, she identified him from an array of photographs shown to her at the time of the interview. (Refer to Justice Center Exhibit 17)

- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

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

The 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 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)(c), including Category 3, which is defined as follows:

> 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 the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has proved by a preponderance of the evidence that the Subject committed the act of neglect as defined in SSL§ 488(1)(h). Offense 1 of the substantiated report alleges that the Subject breached his duty to the Service Recipient, while assigned to provide him 1:1 arms-length by being less than alert and/or asleep.

OPWDD Investigator [redacted] conceded at the hearing that his investigation did not reveal evidence that the Service Recipient removed his feeding tube during the Subject's period of supervision. However, the Justice Center proceeded on the basis that neglect under SSL § 488(1)(h) was established in any case, because the Subject's breach of duty as alleged in

the substantiated report was still likely to result in physical injury, or serious or protracted impairment of the physical condition of the Service Recipient.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the course of the investigation. (Justice Center Exhibits 1 - 17) The investigation underlying the substantiated report was conducted by OPWDD 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.

The Justice Center's main evidence was the written statement of Registered Nurse 1. Registered Nurse 1's written statement indicates that when Registered Nurse 1 returned to the Service Recipient's room approximately one hour after she had warned the Subject that the Service Recipient must be watched carefully as he attempts to remove his NGT, she observed that the Subject had placed a pillow over the Service Recipient's left hand, which had a restraint on it, and that the Subject was asleep with his head on the pillow. The written statement of Registered Nurse 1 further states that Registered Nurse 1 gave the Service Recipient his medications then left the room; however, all the while, the Subject had not awakened. Registered Nurse 1 also reported that throughout the Subject's shift, the Subject spent most of his time watching television and did not interact with or otherwise try to re-direct the Service Recipient from attempting to reach and remove his NGT. (Justice Center Exhibit 10)

During his testimony, the Subject denied that he was sleeping while supervising the Service Recipient and asserted that the fact that the Service Recipient had not removed the NGT during his supervision proved that he had not fallen asleep. Although it was fortunate that the Service Recipient had not removed his NGT during the Subject's shift, that fact alone does not ameliorate the Subject's breach of duty to the Service Recipient.

The Subject testified that the Service Recipient had attempted to remove his NGT multiple times and that he reacted to these attempts by re-directing the Service Recipient with verbal cues, hand over hand assistance and asking him to calm down.

The Subject also argued that the written statement of Registered Nurse 1 should not be given any evidentiary weight because it was neither signed nor dated and she did not testify at the hearing. However, OPWDD Investigator [redacted] testified credibly at the hearing that he had conducted an in-person interview with Registered Nurse 1 on [redacted] in a private setting at the hospital. At that time, Registered Nurse 1 told OPWDD Investigator [redacted] what she observed on the day of the incident, memorialized those observations in a handwritten statement while in his presence and then turned over her statement to him. OPWDD Investigator [redacted] further testified that Registered Nurse 1's written statement had not been altered and that, although it is his practice to ask witnesses to sign and date their statements, he recalled that, at some point during the course of his interview, Registered Nurse 1 was called away to attend to her duties. (Justice Center Exhibit 10)

Furthermore, upon considering the evidence, it is found that the Subject's evidence is self-serving and unreliable. The written statement provided by Registered Nurse 1 contains a high degree of detail as to her observations of the incident, which sufficiently supported the Justice Center's substantiation against the Subject. Moreover, the record does not contain any convincing evidence that Registered Nurse 1 had a motive to be untruthful in her statement, even in view of the Subject's uncorroborated general assertion, made during his testimony, that hospital staff was racially prejudiced towards him. Registered Nurse 1 had no motivation to fabricate her version of the incident, while the Subject had his desire to remain employed as a strong incentive to deny his neglectful conduct. The statement provided by Registered Nurse 1 is

credited evidence. The Subject's testimony that he was properly attentive and did not fall asleep while supervising the Service Recipient was not credited evidence. The convincing evidence in the record established that the Subject fell asleep, or was less than attentive during his assigned period of 1:1 arms-length supervision of the Service Recipient.

While the evidence in the record did not specifically establish with great specificity how long the Subject was asleep, or how long he was less than attentive, the Subject was warned by provider agency staff and hospital staff to closely watch the Service Recipient because the compelling evidence in the record established that the Service Recipient yearned to remove the NGT, and had attempted to do so more than once. This fact was the reason why the Service Recipient had been subject to 1:1 arms-length supervision and even a minor lapse in that supervision provided ample opportunity for the Service Recipient to remove the NGT. Therefore, the Subject's failure to provide proper supervision of the Service Recipient was likely to have resulted in physical injury, or serious or protracted impairment of the physical condition of the Service Recipient. 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 abuse or neglect as set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act. 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 substantiated report dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 3 act.

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

DATED: March 28, 2016
West Seneca, New York