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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

FINAL DETERMINATION AND ORDER AFTER HEARING

Adjud. Case #: [redacted]

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: Todd M. Sardella, Esq.

[redacted]
By: Nicole A. Murphy, Esq.
Fine, Olin & Anderman, LLP
39 Broadway, Suite 1910
New York, NY 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 substantiated report dated [redacted], [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: August 2, 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: Jean T. Carney
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
9 Bond Street, 3rd Floor
Brooklyn, New York 11201
On: [redacted]

Parties: Vulnerable Persons' Central Register
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

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

1. The VPCR contains a "substantiated" report dated [redacted] of 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], while on the [redacted], Wing [redacted] at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide adequate one-to-one supervision to a service recipient, during which time he ingested 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, located at [redacted], is an Intermediate Care Facility (ICF), and is operated by the Office for People With Developmental Disabilities, 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 had been employed by [redacted] for five months. The Subject worked as a Direct Support Assistant (DSA). (Justice Center Exhibit 26)

6. At the time of the alleged neglect, the Service Recipient was a middle-aged male, and had been a resident of the facility for approximately 14 years. The Service Recipient resides on the [redacted] with a primary diagnosis of mild intellectual disability and a secondary diagnosis of schizoaffective disorder. (Justice Center Exhibit 16)

7. The Service Recipient has a history of self-injurious behavior; specifically, scratching himself with sharp objects, and ingesting non-food items, behavior which is also known as PICA. As a result, the Service Recipient was assigned 1:1 enhanced supervision during both the day and evening shifts. This means that staff must be within arms-length of the Service Recipient during those hours. (Justice Center Exhibits 5, 15, 16, and 26; and Hearing testimony of Investigator [redacted])

8. The Service Recipient's Enhanced Supervision Protocol identifies certain warning signs that staff should be alert for, including statements from the Service recipient that he wants to go to the hospital, that he is not feeling well, and that he wants to kill himself. (Justice Center Exhibit 15)

9. On [redacted], the Subject was assigned 1:1 supervision of the Service Recipient during the evening shift. The Subject normally worked on a different unit, but was floated to the [redacted] due to staff shortages. (Hearing testimony of Subject and Justice Center Exhibit 13)

10. During her shift, the Subject noted that the Service Recipient was agitated, and said several times that he wanted to go to the hospital, and that he wanted to die. (Justice Center Exhibit

24) At one point during the evening, the Subject observed the Service Recipient picking at the wall. The Service Recipient ran away from the Subject when she confronted him about this behavior. (ALJ Exhibit 1, audio interrogation of Subject)

11. In the morning of [redacted], the Service Recipient informed staff that he had ingested a staple during the previous evening, while the Subject was assigned as his 1:1 staff person. The Service Recipient pointed to an area near the window, where a cable had been stapled to the wall, and indicated that he obtained the staple there. (Justice Center Exhibit 5)

12. The Service Recipient was taken to [redacted] Medical Center where he was x-rayed, and five staples were found in his lower intestinal tract. The physician reviewing the x-rays determined that the staples had been ingested within 24 hours of the x-rays being taken. The Service Recipient was prescribed a laxative, and a follow up x-ray taken on [redacted], showed no foreign items in his digestive tract. (Justice Center Exhibits 26 and 28)

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 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), to include:

> (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 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 (3), which is defined as follows:

> (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.

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

If the Justice Center proves the alleged 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 neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-29) The investigation underlying the substantiated report was conducted by Independent Investigator [redacted][1], who was the only witness who testified at the hearing on behalf of the Justice Center. The Subject testified in her own behalf and provided no other evidence.

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect when she failed to adequately supervise the Service Recipient, thereby allowing him to access staples which he ingested. Specifically, the evidence establishes that the Subject was aware of the Service Recipient's PICA triggers, including comments such as wanting to go to the hospital, and wanting to die; yet she did not exercise sufficient vigilance in her supervision. As a result, the Service Recipient was able to pick at least five staples off the wall and ingest them.

In order to sustain an allegation of neglect, the Justice Center must show that the Subject acted, or failed to act, or lacked attention in such a manner that it breached her duty to the Service Recipient. In addition, the Justice Center must show that this breach either resulted in, or was likely to result in either physical injury, or a serious or protracted impairment of the physical, or

[1] At the time of the incident, the witness worked for seven different agencies as an Independent Investigator. She was asked to investigate this matter by the Inter-Agency Council.

mental, or emotional condition of the Service Recipient.

Here, the Subject's only duty was to keep the Service Recipient within arm's length, and ensure that he did not engage in any self-injurious behavior, such as PICA. The Subject admitted that during her shift, the Service Recipient was agitated, and stated that he wanted to go to the hospital. The Subject also conceded that she had read the Service Recipient's Behavior Support Program, which specifically states that such behavior is a warning sign of PICA. In addition, the Subject testified that she observed the Service Recipient picking at the wall, and knew that he was looking for something to ingest. (Hearing testimony of Subject and Justice Center Exhibit 16) Therefore, the Subject should have been vigilant in ensuring that he was not able to ingest anything he may have picked off the wall.

The medical records admitted into evidence show that five staples were found in the Service Recipient's digestive tract, probably in the small bowel, and would have been ingested less than 24 hours prior to the time of the x-ray. The x-ray was performed on the Service Recipient at approximately 11:00 am. (Justice Center Exhibits 22 and 28) Therefore, the staples would have been ingested after 11:00 am on [redacted] and before 11:00 a.m. on [redacted].

The Subject argued that the Service Recipient could have ingested the staples during either the day shift on [redacted], or the overnight shift, or even the day shift on [redacted]. However, it is more likely than not that the staples were ingested, or at least obtained, by the Service Recipient when the Subject observed him picking at the wall. The Subject testified at the hearing that the staff assigned to the Service Recipient for the overnight shift informed the Subject that the Service Recipient might have something in his hand. The Subject testified that she told that staff person to report it to a supervisor. The Subject also testified that she reported this encounter to the investigator during her interrogation. However, the audio recording of the

Subject's interrogation does not reflect this. Therefore, that portion of the Subject's testimony is not credited.

Finally, the Service Recipient reported having ingested the staples during the Subject's shift. There is no evidence to contradict this statement. The Subject saw the Service Recipient picking at the wall, and he admitted to ingesting staples, all of which occurred during the relevant time frame. Therefore, it was more likely than not that the Service Recipient obtained the staples at that time, while the Subject was assigned to prevent such behavior.

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 neglect alleged. 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 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.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [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 Jean T. Carney, Administrative Hearings Unit.

DATED: July 25, 2016
Schenectady, New York