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: Jennifer DeStefano, 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 substantiated report dated [redacted] of neglect by the Subject of a Service Recipient 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: November 1, 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

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
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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 report of substantiated finding dated [redacted] of neglect by the Subject of a Service Recipient.

2. The Justice Center's substantiated report against the Subject concluded that:

Allegation 1

It was alleged that on [redacted] at [redacted] of the [redacted] located at [redacted] while acting as a custodian, you committed neglect when you left a service recipient unsupervised after he suffered a head injury.

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, and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center.

[redacted]

5. At the time of the alleged neglect, the Subject, who had been employed at the facility as a Direct Support Assistant in Training (DSAT) for approximately three months, was working the day shift starting at 7:00 a.m. in the facility's House [redacted]. The Subject was assigned to provide supervision to four service recipients, including the Service Recipient, and was a custodian as that term is so defined in Social Services Law § 488 (2). (Hearing testimony of the Subject and Justice Center Exhibit 20)

6. At the time of the alleged neglect, the Service Recipient was a forty three year old resident of the facility's House [redacted] and had been residing at the facility since [redacted] 1995. The Service Recipient is a person with diagnoses of profound mental retardation, chromosomal aberration, autism and numerous other physical and psychiatric issues, which includes self-injurious conduct. (Justice Center Exhibit 16)

7. At approximately 7:30 a.m. on [redacted] while the Subject was assisting another service recipient to get dressed, the Subject heard a noise coming from the Service Recipient's bedroom next door. The Subject went into the next bedroom and observed that the Service Recipient was sitting on the floor beside a toppled over chair and that the Service Recipient had sustained a bleeding head injury. The Subject entered the room, up-righted the chair, pulled the Service Recipient off of the floor and seated him on the chair. (Hearing testimony of the Subject and Justice Center Exhibits 8 and 27)

8. A Direct Support Assistant (DSA) happened to be passing by the Service Recipient's bedroom, while the Subject was with him, and upon observing the Service Recipient's head injury, she suggested that the Subject have the nurse look at it, after which, she returned to what she had been doing. (Hearing testimony of the Subject and Justice Center Exhibits 8 and 27)

9. The Subject then left the Service Recipient unattended in his bedroom, while he

[redacted]

briefly returned to the other service recipient to assist him with his shirt. The Subject then went directly to the nurse's office in House [redacted] to seek medical attention for the Service Recipient. Although the Licensed Practical Nurse (LPN) was on duty, he was not in the nurse's office of House [redacted] at that time. Without checking on the Service Recipient, the Subject then went directly from the nurse's office in House [redacted] next door to House [redacted] to locate the LPN. When the Subject found the LPN in House [redacted] the Subject told him of the Service Recipient's head injury.[1] The LPN sent the Subject back to the Service Recipient to assess the injury more carefully and to then report back to him. (Hearing testimony of the Subject and Justice Center Exhibits 8 and 27)

10. The Subject returned to the Service Recipient's room in House [redacted], where the Service Recipient was still sitting unsupervised and alone, and inspected the Service Recipient's injury more carefully. The Subject then left the Service Recipient unsupervised and alone again, and returned to House [redacted]. Upon consulting with each other, the Subject and the LPN returned to the Service Recipient. (Hearing testimony of the Subject and Justice Center Exhibits 8 and 27)

11. The Service Recipient was given first aid by the LPN and was ultimately taken to [redacted] Medical Center, where he received seven sutures to close his head wound. (Hearing testimony of the Subject and Justice Center Exhibit 22)

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.

[1] The substance of the communication by the Subject to the LPN is unclear. The Subject testified that he disclosed to the LPN that the Service Recipient had a bleeding head wound. (Hearing testimony of the Subject) The LPN's statement (Justice Center Exhibit 10) indicates that the Subject had not told him that the Service Recipient's head was bleeding.

[redacted]

- 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)(h), 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...

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 of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act constitutes 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

[redacted]

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 established by a preponderance of the evidence that the Subject committed the 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 1-27) 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] who, together with OPWDD Staff Development Specialist [redacted], testified at the hearing on behalf of the Justice Center.

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

The Justice Center's case was that the Subject had received relevant first aid and facility training and that he should have known not to leave unsupervised, the Service Recipient who had suffered a bleeding head injury. The Subject acknowledged that he twice left the Service Recipient, whose head was bleeding, sitting on a wooden chair without supervision while he exited the building and went next door to find the nurse on duty to provide medical assistance to the Service Recipient.

The Subject testified that, as a new trainee, he was unaware of the correct protocol for responding to the Service Recipient's head wound and that, as such, he did everything possible to get the necessary medical attention to the Service Recipient as quickly as he could. Furthermore,

[redacted]

he testified that, although he had not explicitly requested the assistance of any other staff, there were other staff present in House [redacted] who were aware that the Service Recipient had a head wound. Lastly, the Subject testified that although he saw that the Service Recipient's head wound was bleeding, it did not appear to him as serious, as it was "only six or seven drops of blood." (Hearing testimony of the Subject)

OPWDD Staff Development Specialist [redacted] is an OPWDD staff trainer and she testified that the standard American Red Cross training includes training on what to do in the case of a bleeding head injury. The crux of OPWDD Staff Development Specialist [redacted] testimony was that the Subject would not have been given the responsibility to work with service recipients unless he had first received American Red Cross first aid training, and that such training includes the topic of responding to bleeding head injuries and, specifically, that the American Red Cross first aid training instructs that head injury victims should never be left alone. She also testified that there were other options available to the Subject, such as requesting that another staff telephone 911 or get the nurse, or requesting that another staff stay with the Service Recipient while he telephoned 911 or went to get the nurse. (Hearing testimony of OPWDD Staff Development Specialist [redacted])

The Subject admitted in his hearing testimony that he had received an American Red Cross certificate of completion of first aid training on [redacted] (Justice Center Exhibit 26), but denied remembering the training regarding bleeding head injuries. (Hearing testimony of the Subject)

The Subject denied familiarity with the [redacted] Head Injury Protocol. (Justice Center Exhibit 14) It states that, regarding less serious looking head injuries, staff are to call a nurse or bring the service recipient to a nurse. When questioned about

[redacted]

his Training Record (Justice Center Exhibit 24), the Subject testified that he did not remember participating in two emergency first aid courses on [redacted] (as reflected in the record), because the courses were just computer courses. (Hearing testimony of the Subject)

In consideration of the facts of this case, it is unnecessary to consult policies and training materials to know that the Subject exercised poor judgment when he left the Service Recipient alone and unsupervised with a bleeding head injury, sitting on a wooden chair, especially given the severity of the Service Recipient's numerous disabilities. The fact that other staff, who were busy elsewhere in the house, may have been aware of the Service Recipient's injury did not put them in a position to prevent the Service Recipient from coming to further harm while he was alone in his room. The Subject had the clear duty to stay with the Service Recipient or to ensure that another staff remained with him.

Given the Service Recipient's disabilities and the fact that he was already injured, the Subject's breach of duty was indeed likely to result in his physical injury or serious or protracted impairment of the physical, mental or emotional condition.

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 report will remain substantiated and the next issue to be determined 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 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 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

[redacted]

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] of neglect by the Subject of a Service Recipient 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 Sharon Golish Blum, Administrative Hearings Unit.

DATED: December 7, 2015
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge