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: Robert DeCataldo, Esq.

[redacted]

By: Samuel J. DiMeglio, Jr., Esq.
141 East Main Street
Huntington, New York 11743

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 granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons Central Register, pursuant to SSL § 493(3)(d).

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: December 29, 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: Justice Center for the Protection of People with Special Needs
125 East Bethpage Road, Suite 104
Plainview, New York 11803
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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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], [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 between [redacted] and [redacted] at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision to the service recipients by not ensuring appropriate protections for them, during which time one of the service recipients repeatedly punched the other service recipient, causing bruising.
>
> 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 operated by [redacted], and is certified 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.

5. At the time of the alleged neglect, the Subject had been employed by [redacted] as a Registered Nurse (RN) at the facility since 2009. Facility staff also included a Residential Supervisor, an Assistant Supervisor, a Service Coordinator and a number of Direct Support Professionals (DSPs). (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was a seventy-four year old verbal ambulatory male facility resident with diagnoses of schizophrenia and mild intellectual disability. (Justice Center Exhibit 13)

7. On [redacted] the facility Residential Supervisor asked the Subject to come into a bathroom, where he showed the Subject a bruise that he had just observed on the Service Recipient's arm. The Subject advised the Residential Supervisor to perform a body check, to complete an Injury Locator Form, and to ask the Service Recipient if he remembered how he got the bruise. (Hearing testimony of the Subject and Justice Center Exhibit 43)

8. The Subject was later told by the Residential Supervisor that the Service Recipient indicated that he got the bruise as a result of being punched by his then roommate, service recipient A. (Hearing testimony of the Subject)

9. On [redacted] an Interdisciplinary Team (IDT) meeting was held to discuss all of the facility service recipients, in which the Residential Supervisor, the Assistant Supervisor, the Service Coordinator and the Subject participated. Because the Subject was required to attend to the health needs of a service recipient who had been transported to a hospital emergency department that day, she left the IDT meeting prior to its conclusion and she was not present when a discussion transpired with respect to service recipient A's punching behavior. (Hearing

testimony of the Subject and Justice Center Exhibit 23)

10. On the evening of [redacted], the Assistant Supervisor was called into the bathroom by a DSP and was shown several bruises on the Service Recipient's arm. The Service Recipient disclosed that the bruises were from punches that he received from service recipient A. The Assistant Supervisor immediately advised the Subject by telephone of the discovery of the new bruises and disclosed that they happened the same way as the last time, which the Subject understood to mean that the bruises were, again, from service recipient A's punches. The Subject advised the Assistant Manager to follow the Bruise Care Protocol (Justice Center Exhibit 30), which included completing an Injury Locator Form and applying ice to the area. After they disconnected, the Assistant Supervisor sent cellphone pictures of the bruises (Justice Center Exhibit 31) to the Subject. (Hearing testimony of the Subject and Justice Center Exhibits 36 and 40)

11. The Assistant Supervisor thereafter telephoned the Residential Supervisor and advised him of the discovery and origins of the new bruises. The Residential Supervisor disconnected to consult with the Operations Director regarding the Service Recipient's bruises and then telephoned the Assistant Supervisor back. The Residential Supervisor instructed the Assistant Supervisor that, thereafter, service recipient A was to be subject to line of sight supervision and, further, that service recipient A and the Service Recipient were to be separated at all times. (Justice Center Exhibit 40)

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 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 neglect of a person in a facility or provider agency is defined by SSL § 488(1)(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...

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 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 not established by a preponderance of the evidence that the Subject committed neglect as described as Allegation 1 in the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-5 and 11-45) The investigation underlying the substantiated report was conducted by the [redacted] Investigator [redacted] who testified on behalf of the Justice Center.

The Subject testified at the hearing and presented evidence on her own behalf. (Subject Exhibits A, B, C, E, F and G)

None of the facts in this case are in dispute. The issue is whether the Subject had a duty to ensure that measures were implemented to protect the Service Recipient from service recipient A's punching behavior on [redacted] and on [redacted] and, if so, whether she breached that duty.

The Subject testified that on [redacted] and on [redacted], she had been advised that the Service Recipient disclosed that bruises on his arm were the result of service recipient A having punched him and, that on both of those occasions, she provided the appropriate instructions to treat the injuries. The Subject testified that her role as facility RN is to ensure that medications are properly administered, to verify compliance with nursing plans and to generally oversee the service recipients' medical care. The Subject testified that as a facility RN she is not responsible, nor does she have the authority, to ensure safety measures or protections are

implemented.

There was no evidence in the record that contradicted the Subject's credible testimony that it is the Residential Supervisor's role to be responsible for presiding over the IDT meetings and that the Subject's presence at such meetings is to provide input regarding only the medical issues that arise. Furthermore, it was undisputed that on [redacted] the Subject was required to leave the IDT meeting early, and was not present when the other participants discussed the issue of service recipient A's punching behavior. The Subject's testimony was given in a forthright manner and was found to be entirely credible.

It is important to recognize the delineation of the different functions of facility staff. On [redacted] the Subject first learned of Service Recipient A's punching behavior from the Residential Supervisor, whose primary and indisputable responsibility it is, as the head administrator of the facility, to monitor incidents and provide post-incident resolutions to protect service recipients. Similarly, on [redacted] the Assistant Supervisor, whose role also involves ensuring protections are implemented in a case such as this, advised the Subject of another punching incident by service recipient A. The Subject would have been responsible for reporting the disclosure of service recipient A's punching behavior to these two staff, had she heard of it from anyone else in the facility. It is these particular staff who are responsible to ensure that protective measures are implemented to prevent the reoccurrence of similar incidents. Ultimately, the evidence in the record establishes that it was the Residential Supervisor who gave the directive to place service recipient A on line of sight supervision and to ensure that two service recipients were separated. Clearly, remedial measures to protect the Service Recipient should have been implemented immediately subsequent to the [redacted] incident, but the delay was not attributable to the Subject and there was no evidence that the Subject was aware that such measures had not been taken.

Also, although this is not determinative, it is worthwhile to mention that, not only did [redacted] Investigator [redacted] testify that he concluded, after a detailed investigation, that the Subject had not committed an act of neglect in this case, but the sixteen professionals who comprised [redacted] Special Incident Committee also found no wrongdoing on the Subject's part.

In the final analysis, based on all of the evidence, it is determined that under the unique facts and circumstances presented by this case, the Subject had no duty to ensure that measures were implemented to protect the Service Recipient from service recipient A, despite her awareness of the Service Recipient's disclosure of service recipient A's punching behavior. Accordingly, it is concluded that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect under SSL § 488(1)(h), as specified in Allegation 1 of the substantiated report.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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

DATED: December 22, 2016
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge