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: Laurie Cummings, Esq.

[redacted]

By: Nicole Murphy, Esq.
Fine, Olin & Anderman, LLP
390 Broadway, Suite 1910
New York, New York 11201

[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 2 act.

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of these reports shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

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 28, 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 Carney
Administrative Law Judge

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

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
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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 on [redacted] at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you breached your duty to supervise and provide care to a service recipient, including failing to maintain required supervision of the service recipient, who fell off of his bed or was dropped on the floor, and/or performing a one-person lift on the service recipient, and/or failing to obtain adequate medical care for, report to nursing staff and/or document that the service recipient was complaining that he was in pain after sustaining a broken hip.
>
> These allegations have been SUBSTANTIATED as a Category 2 neglect pursuant to Social Services Law § 493(4)(b).

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 individuals with developmental disabilities. The [redacted] is operated by [redacted], which is certified by the 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] for approximately four years. The Subject worked as a Direct Care Counselor (DCC). (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 44 year old non-ambulatory male with diagnoses of osteoporosis, scoliosis, cervical thoracic syrinx, progressive quadriplegia and Arnold-Chairi Malformation (ACM), which is a very rare structural condition affecting the cerebellum. The Service Recipient required a wheelchair at all times and had a history of falling. All staff had been trained on falls and proper lifting procedures. (Justice Center Exhibits 6, 21 and 22)

7. On [redacted] working his usual [redacted] shift, the Subject was performing his regular duties, including assisting the Service Recipient with his daily morning activities. Upon the Service Recipient waking, the Subject propped him up in his bed and left the room for about 5 minutes to retrieve the Service Recipient's medications and toiletries to begin his day. Sometime during this interaction with the Subject, or when the Subject left the room, the Service Recipient fell out of bed sustaining an injury to his hip. (Justice Center Exhibit 6)

8. Thereafter, the Service Recipient complained to the Subject that he was experiencing pain in his right leg. The Subject did not call either the residence nurse or the house manager to report the complaint of pain. The Subject helped the Service Recipient transfer from

his bed to the wheelchair and continued with his morning routines of showering, dressing and eating breakfast. (Justice Center Exhibit 6; Hearing testimony of the Subject)

9. After breakfast, the Subject assisted the Service Recipient in boarding the bus for the [redacted]. Shortly after arriving at [redacted], a staff member noticed that the Service Recipient was in pain and when questioned about it, the Service Recipient stated that he had fallen out of bed. The [redacted] staff member immediately notified the [redacted] nurse, who contacted the [redacted] house manager. Questioned by the [redacted] nurse, the Service Recipient disclosed that the Subject had assisted him when he fell out of the bed. (Justice Center Exhibit 6)

10. Upon returning to the [redacted] that afternoon, the residence nurse examined the Service Recipient, noted a fever, and sent the Service Recipient immediately to [redacted] Hospital. A CT scan determined that the Service Recipient had a fractured right hip. Following his hospitalization, the Service Recipient was admitted directly to a Nursing Rehabilitation Facility where he passed away thereafter.

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 abuse and 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 2, which is defined as follows:

> (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one 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 abuse and/or 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 1-24) The investigation underlying the substantiated report was conducted by New York State Justice Center Investigator Christina Rodahan, who was the only witness who testified at the hearing on behalf of the Justice Center. The Subject testified in his own behalf and provided no other evidence.

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect on [redacted] when he breached his duty to properly supervise and provide medical care to the Service Recipient. Specifically, the evidence establishes that the Subject's conduct resulted in the Service Recipient falling off the bed and fracturing his hip. Moreover, the Subject failed to notify the resident nurse and obtain medical treatment for the Service Recipient, who

complained of pain in the right leg following the fall.

As a defense, the Subject maintained that he was not aware of the Service Recipient falling that morning. He testified that he propped the Service Recipient up in bed and left him alone for about 5 minutes and when he returned he was still in the same position. He denied being in the room during the fall and denied helping the Service Recipient after the fall. The Subject admitted, however, that the Service Recipient did complain of pain in his right leg that morning, which the Subject assumed was circulatory related. The Subject testified that he examined the Service Recipient and there was no evidence of bruising or scratches and he expected the pain to subside with the Service Recipient's position change. The Subject further testified that he asked the Service Recipient at the breakfast table if he was okay, to which the Service Recipient answered yes. The Subject admitted that he did not make any notation of the Service Recipient's complaints of pain in the facility Communication Log as was required of him at the end of his shift. (Justice Center Exhibits 6, 9, 24 and Testimony of the Subject)

Upon considering and evaluating the Subject's interrogation and hearing testimony, it is determined that the Subject's statements regarding whether the Service Recipient fell are not credited evidence. The Subject clearly recalled the events leading up to him leaving the Service Recipient propped up in bed and going to get medications. The Subject's testimony became less certain as he testified about returning to the Service Recipient's bedroom after obtaining those medications. During the Subject's interrogation, he was told by the investigator that a failure to report would automatically be a Category 1 and he would lose his job. Thereafter, the Subject was less forthcoming in his answers, most likely due to the fear that he would lose his job if he disclosed any potential mistake in his conduct that morning.

It is clear from the record that the Subject had a long-standing, friendly relationship with

the Service Recipient. It is also clear that the Service Recipient's fondness of the Subject influenced his reluctance to disclose the Subject's involvement in the fall. Nevertheless, as the pain intensified throughout the day and the Service Recipient was questioned about it, he eventually reported to three people at the [redacted] that he had fallen out of his bed that morning and that the Subject had helped him. (Justice Center Exhibits 6 and 24) Furthermore, upon returning to the residence, the Service Recipient privately revealed to the house manager that the Subject was present during the fall. (Justice Center Exhibits 6, 9, 24) Whether the Service Recipient was injured as the result of a fall out of bed or being dropped during a lift, there is no question from the evidence that the Subject failed to properly supervise and provide necessary care to the Service Recipient.

The Justice Center alleged that the Subject violated facility protocol by performing a one person lift instead of the required two person lift which resulted in the Service Recipient's injury. In support of this contention, the Justice Center proffered the Service Recipient's Individual Service Plan (ISP) and Plan of Protective Oversight (PPO) both dated [redacted]. However, these documents contradict each other in stating the supervision level required for the Service Recipient. The ISP indicated that the Service Recipient required 24 hour protective oversight and should always be supervised by staff at the residence, wherein the PPO stated that the Service Recipient requires minimum oversight at the home and staff should provide assistance with activities of daily living as needed. Furthermore, any mention of required lifting procedures is absent from both documents.

Regardless, neglect is defined by SSL §488(1)(h), which reads in pertinent part, " 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…" The Subject clearly failed to properly supervise the Service Recipient which resulted in the Service Recipient falling off his bed and sustaining an injury. This lack of supervision and attention is what gives rise to the substantiation of neglect.

Additionally, it is uncontroverted that the Subject failed to notify either the nurse or the house manager of the Service Recipient's complaint of pain as was required. The Subject further testified that he was aware of the Service Recipient's diagnoses, including his substantial mobility limitations. The Subject acknowledged he had been trained on proper notifications for medical concerns of service recipients and safe lifting techniques. The Subject's conduct constitutes neglect under SSL § 488(1)(h).

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 neglect set forth in the substantiated report. The Subject's failure to properly supervise and his subsequent failure to provide adequate medical care seriously endangered the health, safety and welfare of the Service Recipient. As a result of the Subject's conduct, the Service Recipient suffered a fractured hip. 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 2 act.

Category 2 conduct shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that such custodian engaged in Category 2 conduct.

Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

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 2 act.

This decision is recommended by Jean T. Carney, Administrative Hearings Unit.

DATED: December 20, 2016
Schenectady, New York

Jean T. Carney
Administrative Law Judge