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: Thomas C. Parisi, Esq.

[redacted]
By: Emily Clark, Esq.
Zelenitz, Shapiro & D'Agostino, P.C.
138-44 Queens Blvd., 2nd Floor
Briarwood, New York 11435

[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 abuse and/or 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).

[redacted]

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 11, 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
Brooklyn, New York 11201
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 "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 and 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 of a service recipient in that you failed to perform appropriate bed checks during the overnight shift, failed to obtain medical attention for the service recipient after he fell while not wearing his helmet, failed to document and/or report that the service recipient was not wearing his helmet during the overnight shift and when you were sleeping during the overnight shift.
>
> These allegations have been SUBSTANTIATED as Category 2 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 a model

apartment, operated by the [redacted] an agency certified by the Office for People With Developmental Disabilities (OPWDD), 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 the [redacted] as a Direct Care Counselor (DCC) for two years. (Hearing testimony of Subject)

6. At the time of the alleged neglect, the Service Recipient was [redacted] years old, and had been a resident of the facility for many years. The Service Recipient is an adult male with diagnoses of mental retardation, mood disorder, and seizure disorder. (Justice Center Exhibit 36)

7. The Service Recipient has lost the ability to ambulate long distances and uses a wheelchair. He also has a history of falling. As part of his treatment, he must wear a helmet, except when he is asleep. All staff had been trained in the Service Recipient's helmet protocol. (Justice Center Exhibits 7, and 8)

8. The Service Recipient had been temporarily relocated to the [redacted] model apartment on [redacted]. During the 2:00 p.m. to 10:00 p.m. shift on [redacted] the Service Recipient was taken to the hospital by DCC [redacted] for a CT scan of his head due to unexplained injuries to his face. No fractures were found at that time. DCC [redacted] and the Service Recipient returned to [redacted] close in time to the change in shift. Both DCC [redacted] and DCC [redacted] were working double shifts. Shortly after their return, the hospital called to inform staff that the Service Recipient's helmet had been left at the hospital. Neither the Subject nor the other staff members working that shift informed a supervisor that the helmet had been left at the hospital. (Hearing testimony of Investigator [redacted], Justice Center Exhibits 8, and 30)

9. The Subject was assigned to work the overnight shift, from 10:00 p.m. until 6:00 a.m. When she arrived at [redacted], she saw that there were already two DCCs assigned to the Service Recipient for that shift. She called her supervisor who told her to come back to [redacted] and work at another location. However, the Subject was unable to find a taxi, so she called her supervisor again and left a message saying that she was going back to work her shift at [redacted] with the other two staff members already there. When she arrived back at [redacted], the Service Recipient was in bed. (Justice Center Exhibit 22, and 29)

10. The Service Recipient's Individualized Protective Oversight Plan (IPOP) requires at least two staff assigned to the overnight shift, and one of the two staff members must provide oversight by sitting in close proximity to the Service Recipient's room during the night. (Justice Center Exhibit 7)

11. During the overnight shift on [redacted], the Subject and the other two staff members spent the night in the living room outside of the Service Recipient's bedroom. On [redacted] between 4:00 a.m. and 4:30 a.m., the Service Recipient woke up and tried to move toward his dresser, saying he wanted to get dressed. The Subject and DCC [redacted] heard the Service Recipient yelling, and found him on his knees next to the bed. They assisted the Service Recipient by calming him down and getting him back into bed. (Justice Center Exhibit 31)

12. Later in the morning of [redacted], the Subject was told that the Service Recipient was being moved into an [redacted] that day. The Subject stayed with the Service Recipient while a day shift DCC retrieved the helmet from the hospital. Then the Subject and the other DCC transported the Service Recipient to the [redacted]. (Justice Center Exhibits 27, and 29)

13. When the Service Recipient arrived at the [redacted], the nurse observed bruising and swelling around the eyes, several abrasions on his head, and significant swelling on his right hand. The Subject did not tell the nurse that the Service Recipient had tried to get out of bed earlier that morning. (Justice Center Exhibit 32)

14. On [redacted] the Service Recipient was taken to the emergency room due to a behavioral outburst. While in the hospital, the doctor ordered a CT-scan of the Service Recipient's head to follow up on his facial injuries. The CT-scan showed a fracture of the left zygomatic arch, and an impacted right nasal bone fracture. (Justice Center Exhibits 8, and 35)

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 abuse 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 1-40) The investigation underlying the substantiated report was conducted by [redacted] Special Investigator [redacted], 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 during the overnight shift on [redacted]. Specifically, the evidence establishes that the Subject was acting as a custodian on the night of [redacted]. The Subject breached her duty to the Service Recipient by failing to report to her supervisor that the Service Recipient's helmet had been left at the hospital by other staff members; and by failing to report that the Service Recipient had fallen while trying to get out of bed.

As a defense, the Subject asserts that there were two other staff members present during the shift in question. The Service Recipient's IPOP only requires two staff during the overnight shift, and therefore she was not responsible for any injury that may have occurred because she was an extra person. However, the Subject was acting as a custodian as defined in Social

Services Law § 488 in that she was an employee of a facility certified by OPWDD. (SSL §§ 488[2] and 488[4][a]). She was working that night in her capacity as a DCC. As a result, she was responsible for the Service Recipient the care and supervision of the Service Recipient.

The uncontroverted evidence establishes that between the CT-scan performed in the afternoon of [redacted], and the CT-scan performed on [redacted], the Service Recipient's nose and left cheekbone were broken. (Justice Center Exhibits 35, and 40) Through the process of elimination, [redacted] Special Investigator [redacted] was able to narrow the time frame of the incident to the overnight shift of [redacted], the night before the Service Recipient was transferred to his new [redacted] That was the only time when the Service Recipient did not have his helmet. That was also the only shift when the Service Recipient could have been injured by falling, and hitting his cheek and nose on the dresser in his room. (Hearing testimony of Special Investigator [redacted] Justice Center Exhibits 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 32 and 33)

In addition to the Subject, DCC [redacted] and DCC [redacted] worked that overnight shift, supervising the Service Recipient. DCC [redacted] gave two statements to the investigator, with essentially the same information. She explained that the Service Recipient woke up between 4:00 a.m. to 4:30 a.m. and wanted to get dressed. DCC [redacted] and the Subject went into the Service Recipient's bedroom where the Subject explained to the Service Recipient that it was too early to get up, and they got him back into bed. (Justice Center Exhibits 23, and 31) In her second statement, given eight days after the incident and one day after her first statement, DCC [redacted] gave more details, stating that the Service Recipient had stood up, trying to get to the dresser, but must have fallen to his knees. Additionally, DCC [redacted] second statement explained that the hospital had called shortly before the Service Recipient went to bed, informing

staff that they had left the Service Recipient's helmet at the hospital. (Justice Center Exhibit 31)

DCC [redacted] gave one statement during the investigation. She confirmed DCC [redacted] account of the hospital calling to inform staff that the Service Recipient's helmet was left at the hospital. DCC [redacted] also describes all three staff members sitting in the living room during the night, with the door to the Service Recipient's bedroom remaining open. However, her statement differs from DCC [redacted] statement in that DCC [redacted] stated that the Service Recipient rested peacefully without incident. (Justice Center Exhibit 30)

The Subject gave two statements during the investigation. Both statements corroborate DCC [redacted] statement regarding the Service Recipient trying to get up during the night, and wanting to get dressed. However, the Subject specifically denied in her second statement that the Service Recipient fell. Neither statement mentions the Service Recipient's helmet, most likely because the Subject was not at the apartment when the hospital called. (Justice Center Exhibits 22, and 29) However, during her testimony, the Subject said that she knew the Service Recipient's helmet was not with him during this shift. (Hearing testimony of Subject)

The Subject's testimony at the hearing was inconsistent with both of her statements, as well as the statements of the other staff members. For example, the Subject testified that she called a supervisor that night to get direction regarding the Service Recipient's helmet, but that information was not in any statement. When pressed, the Subject could not remember who she spoke with, or what she was told, or even if she merely left a message. The Subject also testified at the hearing that she was in the same room as the Service Recipient all night, whereas all the written statements, including the Subject's statements, agreed that the staff members were in the living room, and the Service Recipient was in his bedroom.

In addition, the Subject was evasive in answering certain questions. For example, when

asked if she had fallen asleep during her shift that night, she responded that she was allowed a 45 minute break. However, she could not recall if she and the other staff members arranged their breaks so that at least one person was awake at all times, or even if she told the others when she was taking her break. The inconsistencies and glossing over of pertinent details in the Subject's statements coupled with her prevarication at the hearing indicate a lack of credibility. Therefore, the Subject's testimony is not credited evidence.

The Subject breached her duty to the Service Recipient by not seeking medical attention after she found him out of bed, knowing that his helmet was at the hospital and that he was vulnerable to injury from falling. The Subject later accompanied the Service Recipient from the model apartment to the [redacted] She could have discussed his injuries with the nurse who examined him when he arrived at the [redacted], but she did not. The Subject could have explained that his helmet had been left at the hospital prior to her shift, and therefore they were not able to put it on him when he woke up at 4:00 a.m. wanting to get dressed, but she did not. The Subject's inattention and failure to act are causally connected to the subsequent discovery several days later of the Service Recipient's nose and cheekbone fractures.

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.

Having established that 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**.** The Service Recipient suffered a serious injury, breaking his nose and cheekbone. 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.

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 abuse and/or neglect.

The substantiated report is properly categorized, as a Category 2 act.

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

DATED: April 1, 2016
Schenectady, New York

Jean T. Carney
Administrative Law Judge