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: Theresa Wells, Esq.

[redacted]

By: Joseph P. Giruzzi, Esq.
301 Bleecker Street
Utica, New York 13501

[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], received and dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (obstruction of reportable incidents).

The substantiated allegation 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: Schenectady, New York
December 22, 2015

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: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Justice Center
New York State Office Building
333 East Washington Street
Syracuse, New York 13202
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
Appearance Waived.

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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse. 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], received and dated [redacted] of abuse by the Subject of a Service Recipient.

2. After investigation the Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Offense I

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (obstruction of reports of reportable incidents) when you failed to timely report that you had witnessed a co-worker commit an act of abuse and/or neglect when she dragged a service recipient across a floor.
>
> This allegation has been SUBSTANTIATED as Category 3 abuse (obstruction of reports of reportable incidents) pursuant to Social Services Law § 493. (Justice Center Exhibit 1)

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 OPWDD which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse, the Subject was employed by the [redacted] as a Registered Nurse (RN) and had been so employed for eight years. (Justice Center Exhibit 35: audio interrogation of the Subject and Hearing testimony of OPWDD Investigator [redacted]) The Subject was a custodian and also a mandated reporter of abuse and/or neglect as those terms are so defined in SSL § 488 (2) and (5).

6. At the time of the alleged abuse, the Service Recipient was in her mid-forties, and had been in the care of OPWDD for most of her life. The Service Recipient is an ambulatory person with bi-polar disorder and severe mental retardation. The Service Recipient's behavior included property destruction and engaging in self-injurious behaviors, such as banging her head on the floor. (Hearing testimony of OPWDD Investigator [redacted])

7. On [redacted], the Subject was present at the [redacted] from approximately 8:15 a.m. until 8:45 a.m. (Justice Center Exhibit 8, Hearing testimony of OPWDD Investigator [redacted] and Justice Center Exhibit 35: audio interrogation of the Subject)

8. The Service Recipient's Behavior Support Plan includes delineated strategies for staff to use in addressing the Service Recipient's challenging behaviors. These strategies include, among others strategies, ignoring and also re-directing to another activity. If unable to be redirected, a one or two person escort of the Service Recipient to a quieter area of the facility was sanctioned. (Justice Center Exhibit 22, Page 2 and Pages 7-11)

9. On [redacted], between 8:15 a.m. and 8:45 a.m. the Subject witnessed the Service Recipient agitate another service recipient by tossing the other service recipient's magnetic letters on to the living room floor. The Service Recipient then sat down on the floor

and continued to disburse the letters around the floor. This activity greatly agitated the other service recipient.

10. A nearby staff member then positioned herself behind the Service Recipient who was seated on the floor. The staff member then secured the Service Recipient's arms, raised them up over the Service Recipient's head, and dragged the Service Recipient across the floor for a distance of between four and five feet in that position. (Justice Center Exhibit 5, Fifteenth Page, and Justice Center Exhibit 35: audio interrogation of the DS3 who was present in the living room and witnessed the incident)

11. The actions taken by the staff member were not consistent with the Service Recipient's Behavior Support Plan and were not prescribed by the provider agency's adopted Strategies for Crisis Intervention and Prevention-Revised (SCIP-R) training and (PROMOTE) training. This physical intervention was likewise not a prescribed one person escort. (Justice Center Exhibits 27, 32, and 33)

12. The Subject then performed a body assessment of the Service Recipient and found no marks. The Service Recipient did not appear to be distraught. The Subject did not document her body assessment of the Service Recipient. The Subject left the [redacted] at 8:45 a.m. (Justice Center Exhibit 35: audio interrogation of the Subject) Subsequently, redness was noted on the right anterior of the Service Recipient's hand during a physical examination of the Service Recipient which was conducted on [redacted]. (Justice Center Exhibits 24 and 25)

13. On the morning of [redacted], the Subject disclosed to her supervisor the actions which she had observed on [redacted]. The Subject was advised to contact the Justice Center. The Subject next contacted the Service Recipient's mother by email and disclosed the "dragging" which she had observed. (Justice Center Exhibit 29) Later on that date,

the Subject reported the suspected reportable incident to the VPCR. (Hearing testimony of OPWDD Investigator [redacted] and Hearing testimony of the Subject)

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). Under SSL § 488(1)(f) obstruction of reports of reportable incidents is defined as:

> "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state

> agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

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 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, 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 evidence, the substantiated report must be amended and sealed.

DISCUSSION

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

The Subject testified on her own behalf and provided no other evidence.

In support of its substantiated findings, the Justice Center presented a number of documents obtained and a series of audio recordings made during the investigation. (Justice Center Exhibits 1-35) The investigation underlying the substantiated report was conducted by

OPWDD Investigator [redacted].[1]

The Subject was interviewed by OPWDD Investigator [redacted] on [redacted] The Subject told the investigator that she was present during the incident and that she witnessed a staff member grab the Service Recipient's wrists and "drag her half way across the living room." (Hearing testimony OPWDD Investigator [redacted] and Justice Center Exhibit 5, Fifteenth Page, and Justice Center Exhibit 35: audio interrogation of the Subject) The statement provided by the Subject to OPWDD Investigator [redacted] at the time of the investigation is credited evidence.

At the hearing, the Subject testified that during the incident she witnessed another direct care staff member "grab the [Service Recipient] by the wrists and drag her across the living room floor." The Subject's hearing testimony is credited evidence.

The Direct Assistant-3 (DA3) who was present in the living room during the incident was also interviewed by OPWDD Investigator [redacted] on [redacted]. She told OPWDD Investigator [redacted] that she observed another staff member secure the Service Recipient's arms, raise them up over the Service Recipient's head, and drag her across the floor. During the interview, the DA3 estimated the distance that the Service Recipient was dragged to have been between four and five feet. (Hearing testimony of OPWDD Investigator [redacted], Justice Center Exhibit 5, Fifteenth Page, and Justice Center Exhibit 35: audio interrogation of the DA3) The statement provided by the DA3 to OPWDD Investigator [redacted] at the time of the investigation, is credited evidence.

On [redacted], the Subject observed a custodian position herself behind the Service Recipient who was seated on the floor, secure the Service Recipient's arms, raise the

[1] The investigator is now employed by the Justice Center, but was at the time employed by OPWDD.

arms over the Service Recipient's head, and drag the Service Recipient across the floor for a distance of between four and five feet.

In order to establish that the Subject committed the act of obstruction of reports of reportable incidents (abuse), the Justice Center need only to prove that the Subject witnessed a suspected reportable incident, and failed to immediately report the incident to the vulnerable persons' central register (VPCR).

The preponderance of the evidence establishes that on [redacted], the Subject witnessed a suspected reportable incident in that the Subject witnessed the Service Recipient being dragged. The dragging of the Service Recipient is an act which constitutes physical abuse, neglect and also constitutes the deliberate inappropriate use of restraints (abuse). However, the Subject did not, upon discovery, immediately report the suspected reportable incident to the VPCR as is required by SSL § 491 (l) (b).

The statutory definition of deliberate inappropriate use of restraints is helpful:

> "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body. (SSL § 488 (1) (d)).

The action of securing the wrists of the Service Recipient was a mechanical measure which limited the ability of the Service Recipient to freely move her arms and therefore, constitutes a restraint as that term is defined in law. Further, the technique used was deliberately inconsistent with this Service Recipient's Behavior Support Plan (behavioral intervention plan),

generally accepted treatment practices, and/or applicable federal or state laws, regulations, or policies, more specifically SCIP-R and PROMISE training.

While the Justice Center need only to prove that the Subject witnessed a suspected reportable incident, and failed to immediately report the incident to the VPCR, which it did, in this case the Justice Center proved by a preponderance of the evidence that the physical intervention which the Subject witnessed was the reportable incident of deliberate inappropriate use of restraints (abuse) pursuant to SSL § 488 (1) (d).

The statutory definition of physical abuse is also helpful:

> "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person. (SSL § 488(1) (a)).

The physical intervention observed by the Subject included the act of dragging the Service Recipient on her behind, while her arms were secured above her head, for a distance of four to five feet. That physical act constitutes physical contact which caused the likelihood of serious or protracted impairment of the physical, mental, or emotional condition of the Service Recipient.

While the Justice Center need only to prove that the Subject witnessed a suspected reportable incident, and failed to immediately report the incident to the VPCR, which it did, in this case the Justice Center proved by a preponderance of the evidence that the physical intervention which the Subject witnessed was the reportable incident of physical abuse pursuant to SSL § 488 (1) (a).

The statutory definition of neglect is helpful:

> "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. (SSL § 488 (1) (h)).

The physical intervention observed by the Subject included the act of dragging the Service Recipient on her behind, while her arms were secured above her head, for a distance of four to five feet. That physical act constitutes neglect because this action was likely to result in physical injury to the Service Recipient.

While the Justice Center need only to prove that the Subject witnessed a suspected reportable incident, and failed to immediately report the incident to the VPCR, which it did, in this case the Justice Center proved by a preponderance of the evidence that the physical intervention which the Subject witnessed was the reportable incident of neglect pursuant to SSL § 488(1) (h).

Pursuant to SSL § 491 (l) (b), "Allegations of reportable incidents shall be reported immediately to the vulnerable persons' central register upon discovery … [D]iscovery occurs when the mandated reporter witnesses a suspected reportable incident …" The term "immediately" is not statutorily defined. However, the Justice Center interprets the relevant

statute to mean, and argues that for a report to be timely, the report should be made to the VPCR within twenty-four hours of the mandated reporter witnessing a suspected reportable incident. In this case, the Subject waited over seventy-two hours to report the incident to the VPCR.

The Justice Center proved by a preponderance of the evidence that the Subject failed to report a suspected reportable incident immediately upon discovery. Accordingly, it is determined that the Justice Center proved by a preponderance of the evidence that the Subject committed the act of obstruction of reports of reportable incidents (abuse). The substantiated report will not be amended or sealed.

The report will remain substantiated and the next question to be decided is whether the substantiated report constitutes the category of abuse 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 category as a Category 3 act.

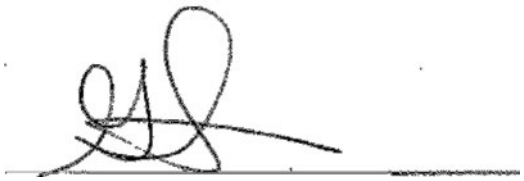
A substantiated Category 3 finding of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report 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], [redacted], received and dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (obstruction of reportable incidents).

The substantiated allegation is properly categorized as a Category 3 act.

This decision is recommended by Gerard D. Serlin, Administrative Hearings Unit.

DATED: December 15, 2015
Schenectady, New York



Gerard D. Serlin, ALJ