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
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Juliane O' Brien, Esq.

[redacted]
By: Ellen M. Mitchell, Esq.
143 Washington Ave
Capitol Station Box 7125
Albany, NY 12224 -0125

[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 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 in part by the Vulnerable Person's 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: April 14, 2015
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: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Office Building
333 East Washington Street
Room 115
Syracuse, New York 13202
On: [redacted]

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Parties: 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 abuse and/or 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 substantiated on [redacted], [redacted], received on [redacted] of abuse and/or neglect by the Subject of the Service Recipient.

2. The initial report was investigated by the Office for People with Developmental Disabilities (OPWDD).

3. On or about [redacted], the Justice Center substantiated the report under the theory that the Subject engaged in *neglect*. The Justice Center concluded that:

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian (LPN), you committed neglect when you operated a service recipient's power wheelchair without securing her foot straps and while pushing a lift motor, resulting in the service recipient catching her foot in a doorway and fracturing her patella.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493.

4. An Administrative Review was conducted and, as a result, the substantiated report was retained.

5. At the time of the alleged neglect, the Subject was employed by the [redacted] at the [redacted], as a Licensed Practical Nurse (LPN). The Service Recipient is a person with a diagnosis of mental retardation, epilepsy, autism, neurological impairment, cerebral palsy (Justice Center Exhibit 8), some bone degeneration, diabetes and also suffered from spasms of the limbs for which she received Botox injections. (Hearing testimony of the Subject)

6. The Subject was employed by *a facility or provider agency* that is subject to the jurisdiction of the Justice Center.

7. The Service Recipient did not ambulate well and utilized both a manual and an electric wheelchair. The Service Recipient was intellectually high functioning, was considered competent enough to make her medical decisions and could refuse wheelchair foot straps. (Hearing testimony of OPWDD Inv. [redacted])

8. The cerebral palsy diagnosis caused or contributed to the Service Recipient suffering from muscles that "flexed straight" or were significant for flexor tone. (Justice Center Exhibit 10) The Service Recipient utilized some type of leg brace. (Hearing testimony of the Subject)

9. The Service Recipient's "Position Plan" relevant to the use of "straps" for the Service Recipient's feet while using any wheelchair states in relevant part that:

> Footwear should be on whenever in either wheelchair[1] (slippers are ok, as long as [Service Recipient] is comfortable). Power wheelchair foot straps do not need to be applied over slippers unless she [service Recipient] wants them on. (Justice Center Exhibit 24)

10. During the course of the investigation the Subject did not tell the investigator that the Service Recipient declined the use of foot straps before the incident at issue. (Hearing

[1] This appears to be a directive that the Service Recipient have some type of footwear on while using any wheelchair whether it be a manual or an electric wheelchair.

testimony of OPWDD Inv. [redacted] and Justice Center Exhibit 31: audio interview with the Subject)

11. On or about [redacted], at approximately 4:30 p.m., the Subject was assisting the Service Recipient who was getting ready to shower. The Service Recipient was negotiating her own electric wheelchair from her room to the bathroom. The Service Recipient's chest and waist strap were fastened in the electric wheelchair. The Service Recipient's feet were not secured in foot straps. Typically, when unsecured in the chair, the Service Recipient's feet pointed outward because of the cerebral palsy related muscle issues. The Service Recipient was wearing socks or stockings (Justice Center Exhibit 31: audio interview with Subject), but was not wearing shoes. (Justice Center Exhibit 11)

12. The Subject was walking in front of the Service Recipient and was simultaneously pushing the Hoyer lift system.[2] The Service Recipient then got stuck in between a dresser and the doorway at which time the Subject took control of the electric wheelchair and manipulated the wheelchair through the doorway into the hallway.

13. The Subject then moved the Hoyer lift into the bathroom and released her hold on the Hoyer lift. As she negotiated the Service Recipient and her wheelchair from the hallway into the bathroom, the Hoyer lift system rolled toward the Subject and the Service Recipient. The reason that the Hoyer lift "rolled" on its own was because the structure was not level. The Hoyer lift had, in the past, "rolled on the track" because the house was not level. The Subject was aware of this "rolling" problem on the relevant date. (Hearing testimony of the Subject)

[2] The "Hoyer lift" system is a pulley or hoist system which runs on a track which is mounted to the ceiling of the [redacted]. The track runs through much of the [redacted]. However, there are multiple track systems within the [redacted] and not one single continuous track throughout the [redacted]. Staff move the lift or hoist along the track from one part of the facility to another part of the [redacted]. At various locations the lift or hoist is used to lift Service Recipients from their bed to a wheelchair or from their wheelchair to a toilet or shower. The lift system is used in other situations as well but the general principle is that the Service Recipient is lifted from, or onto something with the lift. Service Recipients are not transported on the lift via the track system. Any movement of the lift via the track system is for the purpose of getting the lift to a place where it will be utilized to lift a Service Recipient.

14. The Subject turned and made some effort to protect the Service Recipient from the moving Hoyer lift at which time the Subject's gloved hand caught the controller on the wheelchair, causing the wheelchair to accelerate into the door jam and catching the Service Recipient's left foot on the door jamb. (Hearing testimony of the Subject). The Service Recipient also contacted her left knee with the door jamb at this time. (Justice Center Exhibit 11) The Service Recipient heard a "pop" in her "leg." (Justice Center Exhibit 31: audio interview with Service Recipient) However, the Service Recipient did not communicate this to the Subject and the Subject did not hear a noise, like a pop. (Hearing testimony of the Subject). The Service Recipient's knee did not cause her pain immediately after the collision with the door frame. (Justice Center Exhibit 11) However, the impact with the door jamb caused a fracture of the Service Recipient's left Patella.

15. The Subject performed a full body check for injuries of the Service Recipient and this was negative. The Subject then alerted her Supervisor [redacted] that while bringing the Service Recipient into the bathroom the Service Recipient caught her left foot on the door. [redacted], an LPN, examined the Service Recipient's left foot and left leg. She noted no redness, bleeding, bruising or swelling. [redacted] asked the Service Recipient if she wanted to go to the Emergency Room. The Service Recipient stated that she was "O.K." (Justice Center Exhibit 14) The Service Recipient did not want to go to the hospital because she did not think it was "serious." (Justice Center Exhibit 31: audio interview with Service Recipient) The doorways in this residence were of normal width and did not comply with modern door width requirements for wheelchair accessibility. (Hearing testimony of OPWDD Inv. [redacted]) All but one resident, in this residence, were wheelchair bound. (Justice Center Exhibit 31: audio interview with Service Recipient)

16. The Service Recipient and the Subject then continued on with the hygiene routine which included a shower. The Service Recipient did not complain of any pain until dinner time that evening, at which time she complained of minor leg pain (Justice Center Exhibit 18 and Justice Center Exhibit 31: audio interview with Service Recipient) The Subject's shift ended at 11 p.m. (Justice Center Exhibit 31: audio interview with Service Recipient)

17. At approximately 11 p.m. on [redacted], the Service Recipient requested assistance from staff with repositioning herself in bed. At approximately 12 a.m. on [redacted], the Service Recipient requested Tylenol and complained of left knee pain. The left leg was examined by staff and no redness, bruising or swelling was noted. At 4:00 a.m. on the morning of [redacted], the Service Recipient requested more Tylenol for left knee pain. (Justice Center Exhibit 18)

18. On the [redacted], the Subject appeared at work at 7:00 a.m. After some prodding, the Subject convinced the Service Recipient to go to the hospital. The Service Recipient was evaluated at the hospital and diagnosed with a fractured left patella. (Justice Center Exhibit 29)

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 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/or 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 evidence that the alleged act or acts of abuse and/or neglect occurred, …" (Title 14 NYCRR 700.3(f))

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: 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, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse or neglect; and pursuant to Social Services Law § 493(4), the Category of abuse or neglect that such act or acts constitute.

The abuse and neglect of a person in a facility or provider agency is defined by SSL § 488:

> 1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
>
> (a) "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.
>
> (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct

or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

(c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "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.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "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.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(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.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the subject(s) 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 set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse and/or neglect shall be categorized into one or more of the following four categories, as applicable:

    (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

        (i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;

        (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

        (iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

        (iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(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.

(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.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

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 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 neglect, as alleged in the substantiated report. The act committed by the Subject constitutes neglect. The Category of the affirmed substantiated neglect that such act constitutes is a Category 3 act.

In support of the substantiated findings, the Justice Center presented Justice Center Exhibits 1-31. The Justice Center presented the testimony of OPWDD Inv. [redacted]. The Subject testified on her own behalf.

The Justice Center took the position that the Subject should not have, under existing policy or training, simultaneously controlled the wheelchair and Hoyer lift. However, there were no policies internal to the facility, or otherwise introduced, which established a prohibition on simultaneous operation. The Subject's Supervisor rendered the same conclusion in her statement. (Justice Center Exhibit 14) The investigator testified that he found no such policies and also testified that he had little information on facility training of the wheelchair and the Hoyer lift. The Subject testified that she had little to no training in the use of the devices and her training records seemed to support this conclusion. (See Justice Center Exhibit 30)

The second issue is one of interpretation of the "position plan" for the Service Recipient. (See Justice Center Exhibit 24) The Justice Center took the position that the position plan required the use of foot straps when the Service Recipient was transported in the electric wheelchair because the Service Recipient was not wearing shoes. The Subject testified that, and the investigator also concluded, the Service Recipient could refuse the foot strap, at least when being moved intra-facility. The Service Recipient's positon plan is so poorly written that it is not possible to reasonably ascertain whether foot straps were required for the movement in which the collision occurred.

The factual issues presented at the hearing are twofold, but interrelated. The first issue, concerns whether or not the Service Recipient's knee made contact with the door jamb. The only evidence that the Service Recipient's knee made contact with the door jamb is the hearsay statement of [redacted] who is a Senior Occupational Therapist at the facility. [redacted] wrote

that when she interviewed the Service Recipient, she disclosed that "she hit her knee and left foot on the door frame." (Justice Center Exhibit 11) The Subject testified that the Service Recipient's knee never contacted the door frame. Additionally, when interviewed by OPWDD Inv. [redacted], the Service Recipient stated only that her "leg" made contact with the door frame, and no clarification was sought. (Justice Center Exhibit 31: audio interview with the Service Recipient) It is very possible that the Subject simply did not see the Service Recipient's knee contact the door frame. Further, the record is unequivocal; the Service Recipient did not experience knee pain in the immediate aftermath of the collisions.

The only evidence that the Service Recipient's left knee contacted the door jamb is hearsay evidence. Hearsay is admissible in administrative proceedings and an administrative determination may be based solely upon hearsay evidence under appropriate circumstances. *Gray v. Adduci*, 73 N.Y.2d 741 (1988), *300 Gramatan Avenue Associates v. State Division of Human Rights*, 45 N.Y.2d 176 (1978), *Eagle v. Patterson*, 57 N.Y.2d 831 (1982), *People ex rel Vega v. Smith*, 66 N.Y.2d 130 (1985). A crucial concern with respect to hearsay evidence is the inability to cross-examine the person who originally made the statement in order to evaluate his or her credibility. Such evidence, then, must be carefully scrutinized and weight attributed to it would depend upon its degree of apparent reliability. Factors to be considered in evaluating the reliability of hearsay include the circumstances under which the statements were initially made, information bearing upon the credibility of the person who made the statement and his or her motive to fabricate, and the consistency and degree of inherent believability of the statements.

It is well established that hearsay evidence cannot prevail against a witness's sworn and not inherently incredible testimony. *Matter of Perry* 37 AD2d 367 (3rd Dept. 1971), e.g., *In the Matter of the Claim of Lucy Lopez v. the Commissioner of Labo*r. Slip Opinion 514794 (3rd Dept.

January 17, 2013). It is concluded that the Subject did not see the Service Recipient's knee strike the door jamb. Therefore, the Subject was simply mistaken in her testimony.

The hearsay statement of [redacted] regarding what the Service Recipient reported to her about her knee striking the door jamb is, therefore, credited evidence and is corroborated by the "popping noise" reported by the Service Recipient, the development of knee pain in the overnight hours, and finally the definitive diagnosis of a left patella fracture.

The next factual issue to be resolved is whether the Service Recipient striking her left knee on the door jamb actually caused the left patella fracture. The Service Recipient reported to the investigator that she heard something "pop" upon impact. The Subject testified that, and the documentary evidence supports the conclusion that the Service Recipient, who was 65 years of age, suffered from osteoporosis.

The Chief Physical Therapist for [redacted] opined in a written opinion that the Service Recipient's osteoporosis combined with the impact of her left foot on the door jamb caused the left knee fracture. (Justice Center Exhibit 10) The Subject's counsel argued that the opinion of the physical therapist is of little evidentiary value because a physical therapist is not a medical doctor. However, it is not necessary to address the Subject's argument because it is concluded that the Service Recipient fractured her left patella as a result of striking it on the door jamb.

The preponderance of the evidence establishes that the Service Recipient's left knee collided with the door jamb, that the Service Recipient is a 65-year-old female who suffers from osteoporosis, and as a result of this collision, the Service Recipient sustained a left knee fracture.

With regard to the issue of whether or not the Subject should have simultaneously pushed, manipulated or operated the tracking system while also operating the Service Recipient's

wheelchair, the unequivocal evidence in the record established that the Subject had prior knowledge that the tracking system was not level and that the lift was prone to move on its own, causing a potential safety hazard. Given this knowledge the Subject should not have operated the power wheelchair under circumstances in which she might be required to push or engage with the lift to avoid an unsafe situation, such as a "moving" Hoyer lift motor, and in particular near a door way of such limited width. This breach of the Subject's duty resulted in physical injury to the Service Recipient.

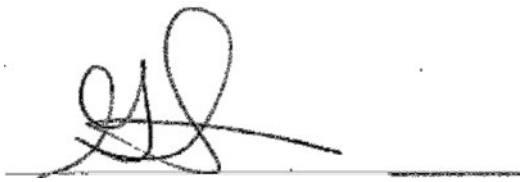
The report should appropriately be categorized as Category 3 neglect. A substantiated Category 3 finding of neglect will not result in being placed on the VPCR Staff Exclusion List and the fact that there is a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry 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 neglect.

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

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

DATED: March 24, 2015
Syracuse, New York



Gerard D. Serlin, ALJ