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: Juliane O'Brien, Esq.

[redacted]

[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 and/or neglect.

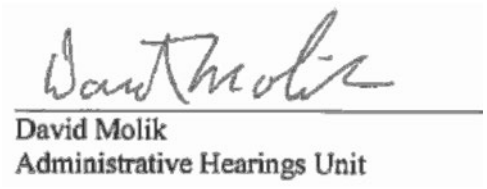
The substantiated report is properly categorized, as a Category 2 act.

NOW THEREFORE IT IS DETERMINED that 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 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: October 16, 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: Jean T. Carney
Administrative Law Judge

Held at: Office of Children and Family Services
Spring Valley Regional Office
11 Perlman Drive
Spring Valley, New York 10977
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.

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

[redacted]

[redacted]

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 Title 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], received and dated [redacted] of abuse and/or 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 [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to observe that the wheelchair ramp of the agency van was not in the correct position to safely move a service recipient onto, but then pushed her anyway, which caused her to fall out of the van.
>
> This allegation has been SUBSTANTIATED as 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 a 14 bed [redacted] for disabled adults and is operated by [redacted],

[redacted]

which is certified by the New York State Office for People With Developmental Disabilities (OPWDD), and is a facility or provider agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 5, and hearing testimony of Investigator [redacted]).

5. At the time of the alleged neglect, the Subject had been employed by [redacted] since [redacted] as a Residential Associate (RA).

6. At the time of the alleged neglect, the Service Recipient was 21 years old, and had been a resident of this [redacted] for approximately eight months, having previously resided in a different [redacted] operated by the same agency. The Service Recipient is a young woman diagnosed with cerebral palsy, seizure disorder, cortical blindness, microcephaly, reactive airway disease, scoliosis, osteoporosis, profound intellectual disability, asthma, allergic rhinitis, and esophageal reflux. She is non-ambulatory and requires total assistance. (Justice Center Exhibit 5).

7. On the afternoon of [redacted], the Subject was assigned to drive the Service Recipient and another resident to a concert. A recently hired RA was assigned to assist her. Although the Subject was not a supervisor, but was more experienced than the other RA, she was placed in charge of this outing. (Hearing testimony of Subject).

8. The Subject successfully completed the [redacted] Driver Training Program on [redacted], and was certified to drive a van equipped with a wheelchair lift. As part of that training, the Subject signed an acknowledgment that she had received and read the [redacted] Vehicle Lift Operating Policy. (Justice Center Exhibits 20, 24, 25, and 26).

9. The Subject drove her co-worker and the residents to the concert where they disembarked the van without mishap. After the concert, the Subject picked up the residents and her co-worker, and drove back to the [redacted]. The Subject had decided that the other RA would

[redacted]

operate the lift while the Subject prepared the residents for off-loading. This arrangement had worked well each time they had loaded and unloaded their passengers thus far. (Hearing testimony of Subject).

10. [redacted] written policy directs staff to communicate with each other during every step of the procedure for loading and disembarking passengers. Of the two staff, the Subject was the trained operator and therefore was primarily responsible for communicating the proper procedure to the ground, or assisting staff. This policy expressly prohibits preparing a second passenger for disembarking prior to the ground staff's presence at the lift. (Hearing testimony of Transportation Supervisor [redacted], Hearing testimony of Subject, Justice Center Exhibits 2, 20, 22, and 24).

11. The Subject and her co-worker successfully off-loaded the first resident from the van. While her co-worker wheeled that resident toward the [redacted], the Subject began to release the straps which were holding the Service Recipient's wheelchair to the floor of the van. Without checking to ensure that the wheelchair lift had been raised and locked, the Subject started moving the wheelchair off the van. The lift had not been raised, and the Service Recipient, securely strapped into her wheelchair, tipped out of the van and fell more than two feet, landing with her face coming into contact with the grate of the lift where she landed. (Hearing testimony of Investigator [redacted], Justice Center Exhibits 2, 4, 5, 7, 8, 9, 31, and 32).

12. The facility nurse provided first aid, cleaned the Service Recipient's cuts, and applied ice until the ambulance arrived. The Service Recipient suffered from injuries to her forehead, nose, scalp, and abdomen. The hospital performed x-rays, a CAT scan of the head, and a CT scan of the spine due to her history of spinal stabilization surgery. (Justice Center Exhibits 5, 11, 12, 13, and 17).

[redacted]

13. In addition to the physical injuries, the Service Recipient suffered emotional trauma. She was crying while the nurse tended to her wounds; and staff was concerned about her comfort level in boarding and disembarking the van for subsequent outings. (Hearing testimony of Investigator [redacted], and Justice Center Exhibit 4).

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 neglect presently under review was substantiated. A "substantiated report" means a report "wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR § 700.3(f))

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

[redacted]

> 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 neglect, which is defined as follows:

> 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(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 as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR § 700.10(d), it must then be determined whether the act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

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.

[redacted]

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

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed a prohibited 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 1-36). The investigation underlying the substantiated report was conducted by The [redacted] Investigator [redacted], who testified on behalf of the Justice Center at the hearing along with Transportation Supervisor [redacted]. The Subject testified on her 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 she failed to ascertain whether the wheelchair lift was raised and locked so as to safely disembark the Service Recipient from the van at the [redacted] in [redacted]. As a result of the Subject's lack of attention, the Service Recipient was injured, and it was foreseeable that the Service Recipient could have been seriously injured.

There is no substantial disagreement concerning the facts. The Justice Center contends that the Subject failed to follow the established policy and procedure for which she had been trained, and that this failure resulted in significant injuries to the Service Recipient.

The Subject had been working as an RA for [redacted] approximately one year and seven months when this incident occurred. Her job entailed taking care of the residents' day-to-day activities. Among the Subject's duties was assisting in the transportation of residents in a 15 passenger lift van retrofitted to transport non-ambulatory people. (Hearing testimony of

[redacted]

Subject, hearing testimony of Investigator [redacted], Justice Center Exhibit 22).

The Subject was certified as a van driver and wheelchair lift operator on [redacted], more than four months prior to this incident. This certification was in addition to the training the Subject received when she was hired. Transportation Supervisor [redacted] testified that every employee is trained during their orientation on how to operate the wheelchair lift. In order to be certified as a van driver, employees must successfully complete an additional three hour course that includes hands-on instruction, practice driving the van, and practice operating the lift. By her own testimony, the Subject had used the wheelchair lift nearly every day while employed at the facility. (Hearing testimony of Transportation Supervisor [redacted], hearing testimony of Subject; and Justice Center Exhibits 18, 25, and 26).

At the time of the incident, the [redacted] policy regarding wheelchair lift operations specifies that when off-loading more than one passenger, the employee in the van cannot prepare the next passenger for the lift until the ground staff is present at the lift. (Justice Center Exhibit 20). In this case, the uncontroverted evidence shows that the ground staff was at the door of the residence with the first passenger when the Subject removed the straps securing the Service Recipient's wheelchair to the van floor. (Hearing testimony of Subject; and Justice Center Exhibits 5 and 9).

The Subject testified that she was in charge of the van that day. Therefore it was her responsibility to effectively communicate and coordinate with the ground staff. Instead, the Subject started to prepare the Service Recipient for disembarking without determining whether the wheelchair lift was in the proper position to receive the Service Recipient. In addition, the Subject saw her ground staff standing some distance away from the van. The Subject's failure to wait until her co-worker returned to the van before preparing the Service Recipient for off-

[redacted]

loading violated the [redacted] policy and consequently she breached her duty to the Service Recipient. (Hearing testimony of Subject, and Justice Center Exhibit 20).

Finally, not only did the Subject prematurely prepare the Service Recipient for disembarking, but she also started pushing the Service Recipient's wheelchair off the van without ensuring that the lift was in position, and despite knowing that her co-worker was some distance from the van and not in position to receive the Service Recipient. As a result, the Service Recipient sustained significant injuries and was taken to the hospital where she underwent several tests to determine the extent of her injuries. (Hearing testimony of Investigator [redacted], and Justice Center Exhibit 12).

The Service Recipient is an extremely fragile young woman with numerous disabilities, and is completely dependent upon her caretakers. She is blind, has global developmental delay and is kept immobile in her wheelchair due to her physical frailty. One can only imagine her terror as she was pushed into thin air, landing on a hard metal grate several feet below. (Justice Center Exhibits 5, 11, and 17).

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 level of abuse or neglect set forth in the substantiated report. Due to the injuries suffered by the Service Recipient, as well as the reasonable foreseeability of how seriously the Service Recipient could have been injured; and based upon the totality of the circumstances, the evidence presented and the witnesses'

[redacted]

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], [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 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: September 25, 2015
Schenectady, New York

Jean T. Carney
Administrative Law Judge