STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

FINAL DETERMINATION AND ORDER AFTER HEARING

Adjud. Case #: [redacted]

Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Thomas C. Parisi, Esq.

[redacted]
By: Antonio Cavallaro, Esq.
52 Broadway, 9th Floor
New York, New York 10004

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

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

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

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: January 23, 2017
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: Mary B. Rocco
Administrative Law Judge

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

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
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: Antonio Cavallaro, Esq.
52 Broadway, 9th Floor
New York, New York 10004

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [redacted], [redacted] of neglect by the Subject of a Service Recipient.

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

Allegation 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to use the proper technique while bringing a service recipient through the doorway to the residence, causing a humeral fracture.
>
> 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 residential [redacted] for individuals with acute developmental disabilities, and is operated by [redacted]. [redacted] is certified by the New York

State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted] Senior Operations Coordinator [redacted])

5. At the time of the alleged neglect, the Subject had been employed by [redacted] as a Residence Program Specialist (RPS) since [redacted], 2013. The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was a 48 year old, non-verbal female who was confined to a wheelchair and required full staff assistance for all activities of daily living. The Service Recipient had been a resident of the facility for approximately 26 years with diagnoses of Cerebral Palsy, profound mental retardation, Rhett's Syndrome, Quadriplegia, and seizure disorder. The Service Recipient attended a daily [redacted] located directly across the street from the facility. (Justice Center Exhibits 6, 31, 33 and 34)

7. Approximately six months prior to the alleged neglect, an enclosed exterior vestibule was installed at the rear entrance of the [redacted] to provide shelter from inclement weather to the service recipients and staff. The structure consisted of a fabric and plastic covering over a metal frame with a self-closing metal door. At the time of the incident, the door did not have a doorstopper or any mechanism to hold the door open. (Hearing testimony of [redacted] Senior Operation Coordinator [redacted] and Subject Exhibit A)

8. On [redacted] at approximately 2:35 p.m., the Subject, working her normal afternoon shift and conducting her regular duties, picked up the Service Recipient from [redacted]. The Subject manually navigated the Service Recipient's wheelchair across the street, through the vestibule and into the facility's rear door. (Hearing testimony of the Subject and Justice Center

Exhibits 6, 9, and 10)

9. As the Subject attempted to hold the vestibule door open and, at the same time, maneuver the wheelchair forward facing through the doorway, the Service Recipient's left elbow became wedged up against the doorframe. The Subject continued to push the wheelchair through the doorway causing the Service Recipient's arm to twist with the force from the push and resulted in injury to her left arm. (Justice Center Exhibits 6, 29, 30 and 37) The Subject continued into the facility toward the elevators where she left the Service Recipient who began whimpering in pain. The Subject shouted to the case manager in his office to watch after the Service Recipient so the Subject could continue picking up other service recipients from [redacted]. (Hearing testimony of the Subject and Justice Center exhibits 6, 28)

10. Upon hearing the Service Recipient's cry, the facility Registered Nurse (RN) evaluated her and immediately sent her to the hospital where she was diagnosed with a left humeral fracture. (Justice Center Exhibits 6, 23, 24, 25, 26, 27, 30)

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, 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 committed the act or acts of neglect alleged in the substantiated report

that is the subject of the proceeding and that such act or acts constitute the category of neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d)).

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

If the Justice Center did not prove the abuse and/or 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. Specifically, the evidence establishes that the Subject's improper technique of transporting the Service Recipient showed a complete lack of attention to the safety of the Service Recipient. As a result of the Subject's careless conduct, the Service Recipient was seriously injured.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-37) The investigation underlying the substantiated report was initially conducted by [redacted], [redacted] Coordinator of Operations, and was thereafter transferred to [redacted], Senior Operations Coordinator [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 three documents as evidence. (Subject Exhibits A, B and C)

The Justice Center proffered evidence in the form of a timeline including statements from both the [redacted] and facility staff as well as objective medical testing that confirmed the Service

Recipient's fractured humerus. (Justice Center Exhibits 11-28 and 30) Through a re-enactment, the [redacted] Investigator was able to narrow down the timeframe of the injury to the approximate 2 minutes it took for the Subject to transport the Service Recipient from the [redacted] to the facility. Through a simulation of maneuvering the Subject's wheelchair through the doorway, and in conjunction with the witness statements that were obtained, the investigation revealed that the moment of entry into the facility was the only time during which the injury could have taken place. (Hearing testimony of [redacted] Senior Operations Coordinator [redacted] and Justice Center Exhibits 6 and 11-28)

The Subject provided two handwritten statements during the investigation in which she denied any injury to the Service Recipient. In both statements she stated that the Service Recipient was fine, exhibiting no sign of discomfort when she picked her up from the [redacted]. The Subject further asserted in her statements that she did not encounter any issue or struggle with the facility's vestibule door or with navigating the wheelchair through it. The Subject stated that she approached the door with the wheelchair facing toward the door and opened it with her left hand while pushing the wheelchair through with her right hand. The Subject explained further that she used her right leg to hold the door open in order to push the wheelchair through the doorway. Asked a number of times during the interview, the Subject denied that the wheelchair or any part of the Service Recipient's body came in contact with the door or the doorframe. (Justice Center Exhibits 9 and 10).

In her testimony, however, the Subject contradicted her prior two statements and admitted that while she was maneuvering the Service Recipient's wheelchair through the vestibule doorway, she used the wheelchair to hold the door open, then utilized her right leg to disengage the wheel lock on the wheelchair and then pushed the wheelchair through the doorway. During the hearing,

the Subject physically demonstrated each step she took navigating the Service Recipient's wheelchair through the vestibule doorway. With her demonstration and with the assistance of the photographs she provided, the Subject provided an illuminating and helpful re-enactment of the technique she utilized that afternoon. (Hearing testimony of the Subject and Subject Exhibits A, B and C) Her re-enactment depicted an awkward and haphazard manner in which she held the door open with her right hand which would be furthest from the door and maneuvered the occupied wheelchair. It was clear from this demonstration that the Subject's reckless conduct posed a serious risk to the Service Recipient's safety and welfare. Although there was no specific facility policy or protocol in evidence regarding the maneuvering of a wheelchair through a doorway, if the technique caused an injury, as it did here, it was clearly an improper technique.

Counsel for the Subject argued that the written statements of the facility RN, who found the Service Recipient whimpering in her wheelchair following her return to the facility, should not be given any evidentiary weight. Counsel argued that the facility RN violated protocol by removing the Service Recipient's coat without the required two person assist and could have possibly caused the injury. Counsel further argued that because the facility RN did not testify at the hearing, her statements should be discredited. However, the five written statements provided by the facility RN during the investigation each contain a high degree of detail as to her observations of the incident, which sufficiently substantiate the allegation against the Subject. The assertion that the facility RN may have caused the injury lacks merit as well, especially considering that it was the sound of the Service Recipient's whimpering that triggered the RN's initial involvement. (Justice Center Exhibits 23, 24, 25, 26, 27 and Hearing testimony of [redacted] Senior Operation Coordinator [redacted])

Counsel for the Subject further argued that the Service Recipient's injury was so severe in

nature that it would have caused an immediate outburst of pain, and because the Service Recipient didn't start whimpering immediately upon entering the facility, the Subject therefore did not cause the injury. The evidence does not support this contention. The record clearly established, and the Subject admitted, the Service Recipient began whimpering in pain approximately 25 seconds after entering the facility. The record also establishes that this non-verbal, non-ambulatory Service Recipient was only able to express herself through facial expressions and a delay in a verbal expression of pain by the Service Recipient would be reasonable and consistent with her facility treatment plans and witness statements. (Justice Center Exhibits 6, 9, 10, 11, 12, 31, 33, and 34; Hearing testimony of the Subject)

The Subject breached her duty to the Service Recipient by haphazardly and carelessly maneuvering the Service Recipient's wheelchair through the vestibule doorway causing her physical injury.

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 neglect set forth in the substantiated report. As a result of the Subject's conduct in recklessly maneuvering the Service Recipient's wheelchair through the vestibule doorway, the Service Recipient's health, safety, and welfare were seriously endangered. The Service Recipient suffered a fractured left humerus. 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], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

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

This decision is recommended by Mary B. Rocco, Administrative Hearings Unit.

DATED: January 18, 2017
Brooklyn, New York

Mary B. Rocco
Administrative Law Judge