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: Theresa Wells, Esq.

[redacted]

By: Jessica M. Peraza, Esq.
Terry M. Sugrue & Associates, LLP
135 Delaware Avenue, Suite 410
Buffalo, New York 14202

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

ORDERED: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed is denied.

The Subject has been shown by a preponderance of the evidence to have committed abuse and 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 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: February 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: John T. Nasci
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
2165 Brighton Henrietta Town Line Road
Rochester, New York 14623
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
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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 neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

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

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

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

Allegation 2[1]

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed physical abuse and/or neglect when you forcefully pushed a service recipient's arms down to his lap and/or onto the arms of his wheelchair and quickly spun the wheelchair around.
>
> This allegation has been SUBSTANTIATED as Category 3 physical abuse and Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

4. The facility, the [redacted], located at [redacted], is a group home for people with

[1] Allegation 1 was unsubstantiated prior to the hearing.

developmental disabilities, and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted], OPWDD Internal Investigator[2])

5. At the time of the alleged abuse and neglect, the Subject had been employed by the OPWDD as a Developmental Services Aide (DSA) for three years and had worked at the [redacted] for nine months. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged abuse and neglect, the Service Recipient was a fifty-four year old adult male and had been a resident of the facility for six to seven months. The Service Recipient was legally blind and diagnosed with mild/moderate mental retardation, organic brain syndrome, passive developmental disorder - NOS, seizure disorder, mild hearing loss and anxiety/OCD. The Service Recipient was also legally blind. (Justice Center Exhibits 13 and 14, and Hearing testimony of the Subject)

7. At the time of the alleged abuse and neglect, the Service Recipient was ambulatory only with the assistance of two staff and a gait belt. The Service Recipient was transported outside the [redacted] in a wheelchair. The Service Recipient had the capability of moving himself with his arms and legs while in the wheelchair. (Justice Center Exhibits 14 and 15, and Hearing testimony of the Subject)

8. At the time of the alleged abuse and neglect, the Service Recipient had limited communication skills but was able to print words and simple sentences. The Service Recipient was also able to read, write and participate in household activities. (Justice Center Exhibits 13 and 15, and Hearing testimony of the Subject)

[2] [redacted] was employed as an OPWDD Internal Investigator at the time of the allegations but is presently employed by the New York State Department of Health.

9. The Service Recipient's target behaviors were self-injurious behaviors (SIB) and agitation. Methodologies prescribed for use in reaction to the Service Recipient displaying his targeted behaviors include, in progressive order: 1) asking the Service Recipient to identify who or what is disturbing him and reassuring him that staff is there to help; 2) handing the Service Recipient paper and pen which he can use to express his thoughts through writing; 3) offering the Service Recipient praise and help to problem solve; 4) continuing to encourage him; 5) using verbal or nonverbal calming techniques and redirecting the Service Recipient to a preferred activity; and 6) if the Service Recipient is engaging in SIB, notifying a nurse for further instruction. (Justice Center Exhibits 13 and 14)

10. At the time of the alleged abuse and neglect, the Service Recipient's health had deteriorated to a point where he needed a feeding tube, had lost a lot of weight and was frail. Due to his deteriorated health, the Service Recipient was more susceptible to bruising and breaking bones. (Justice Center Exhibit 21 and Hearing testimony of the Subject)

11. On [redacted], the Subject worked at the [redacted] from 2:00 p.m. to 10:00 p.m. and was assigned to take the Service Recipient to the hospital for a medical appointment. Upon arriving at the hospital, the Service Recipient realized where they were and became agitated because he did not like medical appointments. The Service Recipient put his hands on the wheelchair wheels to try to prevent the Subject from taking him into the hospital. As a result, the Subject took the Service Recipient's hands and placed them in his lap. (Justice Center Exhibit 21 and Hearing testimony of the Subject)

12. Upon arriving at the physician's office inside the hospital, the Subject entered the waiting room of the office with the Service Recipient, went to the reception window and checked in with the receptionist. Thereafter, the Subject positioned the Service Recipient in the waiting room so that he was able to see out a window, and then she sat down across from the reception

window. A few minutes later a male patient came into the waiting room, checked in with the receptionist and sat down next to the Subject. A few minutes later, a delivery man came into the waiting room, dropped off a package with the receptionist and left. A few minutes after entering the waiting room the Service Recipient was called into an examination room, and the Subject moved the Service Recipient in his wheelchair from the waiting room to the examination room. (Justice Center Exhibit 21 and Hearing testimony of the Subject)

13. Between the time that the Subject and the Service Recipient entered the waiting room and the time that the Subject and Service Recipient entered the exam room, the Service Recipient became increasingly agitated. The Service Recipient expressed his agitation by moaning and by repeatedly moving his right arm behind him attempting to pinch the Subject. Each time that the Service Recipient did this, the Subject grabbed the Service Recipient's arm, placed it forcefully on his lap and back within the confines of the wheelchair, and told him not to pinch her again. (Justice Center Exhibits 9 and 17)

14. After being called into the examination room, the Subject turned the Service Recipient's wheelchair around and pulled the Service Recipient through the examination room doorway backward to prevent the Service Recipient from resisting his entry into the examination room by grabbing the doorway with his hands. (Hearing testimony of the Subject)

15. The only people present in the examination room were the Subject, the Service Recipient and an office nurse. While in the examination room, the Service Recipient continued to attempt to pinch the Subject and the Subject continued to place the Service Recipient's arm forcefully on his lap and back within the confines of the wheelchair. (Justice Center Exhibits 9 and 17)

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/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 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)(a) and (h):

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

If the Justice Center proves the alleged abuse and 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 neglect cited in the substantiated report constitutes the category of abuse and neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and 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 2" 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 through 21) The investigation

underlying the substantiated report was conducted by [redacted], OPWDD Internal Investigator, who was the only witness to testify at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented no other evidence.

The Justice Center alleges that the Subject forcefully pushed the Service Recipient's arms down to his lap and/or onto the arms of his wheelchair and quickly spun the wheelchair around, and that neither action by the Subject was allowed or sanctioned by the Service Recipient's treatment plans. The Justice Center's evidence presented in support of its allegations includes the statements of the medical office receptionist and the medical office nurse. Both witnesses reported that several times they witnessed the Service Recipient put his arm out and the Subject slam the Service Recipient's arm back down. Both also reported that the Subject whipped the Service Recipient's wheelchair around so that the Service Recipient could not see them. (Justice Center Exhibits 9 and 17)

The Subject admits guiding the Service Recipient's arm back inside the confines of his wheelchair after the Service Recipient reached behind his wheelchair and attempted to pinch her. The Subject described her actions as cupping her hand under his upper arm, then moving her hand to a point under his elbow and then moving the Service Recipient's arm inside the confines of the wheelchair. The Subject stated that she had seen other staff use this procedure and that it was protocol to keep service recipients' arms close to their bodies when in public places. The Subject also admitted that she turned the Service Recipient's wheelchair around when she and the Service Recipient entered the examination room so as to thwart the Service Recipient's attempts to block his entrance into the room. The Subject further admitted to using some level of increased force to get the wheelchair over the threshold between the waiting room and the examination room. (Justice Center Exhibits 17 and 21, and Hearing testimony of the Subject)

Physical Abuse

The Justice Center proved by a preponderance of the evidence that the Subject committed physical abuse when she forcefully moved the Service Recipient's arm from outside the wheelchair to within the confines of the wheelchair. The Justice Center did not prove by a preponderance of the evidence that the Subject committed physical abuse by quickly spinning the Service Recipient's wheelchair around.

In order to prove physical abuse, the Justice Center must establish that the Subject intentionally or recklessly caused, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient or caused the likelihood of such injury or impairment. (SSL §488(1)(a)) The terms "intentionally" and "recklessly" are defined by Social Services Law as having the same meanings as provided in New York State Penal Law. (SSL §488(16)) New York State Penal Law states that "A person acts intentionally with respect to a result or to conduct ... when his conscious objective is to cause such result or to engage in such conduct." (PL §15.05(1)) New York State Penal Law states that

> "A person acts recklessly with respect to a result or to a circumstance ... when he is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation ..." (PL §15.05(3))

The record is clear that several times the Subject moved the Service Recipient's arm from outside the confines of his wheelchair back within the confines of his wheelchair when the Service Recipient attempted to pinch the Subject. The dispute between the parties is over the amount of force used by the Subject when she moved the Service Recipient's arm. The Justice Center presented the statements of two witnesses, each of whom saw the Subject's actions separately (the receptionist in the waiting room and the nurse in the examination room) and both of whom described the Subject's actions as "slamming" and "somewhat forcefully." (Justice Center

Exhibits 9 and 17) The Subject described her actions as "guiding" or "placing." (Justice Center Exhibits 17 and 21, and Hearing testimony of the Subject) The Subject presented no evidence of any motive of the receptionist and/or the nurse to fabricate their statements.

It may only be a matter of a difference in perception between the Subject and the witnesses, however, it seems clear that what the two medical professionals witnessed the Subject doing, was an amount of force in excess of that which was necessary or proper. The nurse also described the Subject as appearing frustrated by the Service Recipient's conduct. (Justice Center Exhibit 17) The receptionist's description is supported by the Subject's own assessment of the situation that the Service Recipient was difficult to deal with and was resisting, and that she was not able to redirect the Service Recipient. (Justice Center Exhibits 12 and 17, and Hearing testimony of the Subject)

Without any evidence that the witnesses were exaggerating or fabricating their recounting of the Subject's actions, the witnesses' statements are credited evidence and the Subject's description of the amount of force she used is not credited evidence. As a result, it is determined that the Subject used excessive force when she moved the Service Recipient's arms from outside the wheelchair to within the confines of his wheelchair.

The Subject was aware of the Service Recipient's frail condition and that he was highly susceptible to bruising. (Justice Center Exhibit 21 and Hearing testimony of the Subject) By forcefully moving the Service Recipient's arm to within the confines of his wheelchair, the Subject consciously disregarded an elevated risk of bruising the Service Recipient. Because of the elevated risk of bruising, the Subject's actions are determined to have been a gross deviation from the standard of conduct that a reasonable person would observe in a similar situation. Consequently, it is determined that the Subject acted recklessly.

Furthermore, while there was no evidence of actual harm to the Service Recipient as a

result of the Subject's actions, the record reflects that because of the elevated risk of bruising to the Service Recipient, there was a likelihood that Subject's actions would result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Finally, the Subject presented no evidence, nor is there any in the record, that her actions were a reasonable emergency intervention necessary to protect the safety of the Service Recipient or any other person.

Consequently, the Justice Center has proven by a preponderance of the evidence that the Subject committed physical abuse by forcefully moving the Service Recipient's arm from outside the confines of his wheelchair to within the confines of his wheelchair.

The Justice Center also alleges that the Subject committed abuse by quickly spinning the Service Recipient's wheelchair around. The Justice Center's evidence included the statements of the medical office receptionist and the medical office nurse. The joint written statement of the receptionist and nurse states that "the staff member ... whipped his wheelchair around so that he could not see her." (Justice Center Exhibit 9) However, in their individual statements to the New York State Police, the receptionist stated that the Subject "turned the wheelchair so that it was facing away from her", and the nurse did not mention anything about the Subject turning the Service Recipient's wheelchair around. (Justice Center Exhibit 17) Because the evidence is conflicting and not corroborated, the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed physical abuse by quickly spinning the Service Recipient's wheelchair around.

Neglect

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect when she forcefully moved the Service Recipient's arm from outside the wheelchair to within the confines of the wheelchair. The Justice Center did not prove by a preponderance of the evidence that the Subject committed neglect by quickly spinning the Service Recipient's wheelchair around.

In order to prove neglect, the Justice Center must establish that the Subject breached a custodian's duty and that resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL §488(1)(h))

The Justice Center contends that the Subject's conduct, of forcefully physically moving the Service Recipient's arm from outside the confines of his wheelchair to within the confines of his wheelchair, was not allowed or sanctioned by the Service Recipient's treatment plans. The Subject contends that her conduct was part of protocol and that she had learned it by witnessing other staff performing the procedure. (Hearing testimony of the Subject) The Subject provided no credible evidence that the procedure she described was allowed or sanctioned by the facility.

The record reflects that the Service Recipient dislikes medical appointments. (Justice Center Exhibit 21 and Hearing testimony of the Subject). The Service Recipient's Behavior Support Plan acknowledges the Service Recipient's anxiety about scheduling and attending medical appointments and provides a clear continuum of reactive methodologies to employ in order to relieve his anxiety. One of the reactive techniques included in the continuum is handing the Service Recipient a pen and paper so that he can express his thoughts through writing. (Justice Center Exhibit 14) The record reflects that the Subject did not do this. In any event, the continuum did not include the use of physical force of any level. The Subject had a duty to follow the Service

Recipient's treatment plans and her failure to follow the Service Recipient's Behavior Support Plan was a breach of that duty.

As stated above, the record reflects, that because of the Service Recipient's frail health, he was experiencing an elevated risk of bruising. Although there is no evidence of actual injury to the Service Recipient, the Subject's actions were likely to result in physical injury or serious or protracted impairment of the physical condition of the Service Recipient.

Consequently, the Justice Center has proven by a preponderance of the evidence that the Subject committed neglect by forcefully moving the Service Recipient's arm from outside the confines of his wheelchair to within the confines of his wheelchair.

The Justice Center also alleges that the Subject committed neglect by quickly spinning the Service Recipient's wheelchair around. As stated above, the evidence presented by the Justice Center in support of this allegation is conflicting and uncorroborated and, therefore, the Justice Center has not established that the Subject quickly spun the Service Recipient's wheelchair around. Consequently, the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed neglect by quickly spinning the wheelchair around.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. 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 3 act.

Substantiated Category 3 findings 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

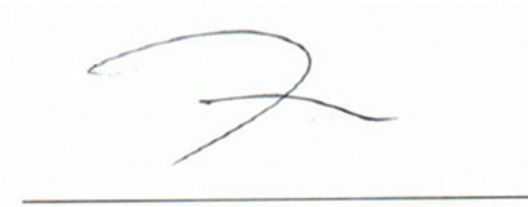
VPCR. However, the report remains subject to disclosure pursuant to SSL § 496 (2). The report will be sealed after five years.

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

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

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

DATED: February 21, 2017
Schenectady, New York



John T. Nasci, ALJ