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 Parisi, Esq.

[redacted]
By: Emily G. Hannigan, Esq.
Lippes Mathias Wexler Friedman, LLP
54 State Street, Suite 1001
Albany, New York 12207

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 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: March 20, 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 Office Building
44 Hawley Street, Room 1701
Binghamton, New York 13901
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State 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 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], while on an outing in the community and away from the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision to a service recipient, during which time her wheelchair tipped over and she hit her head, causing a brain injury.
>
> 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, the [redacted], located at [redacted], is a facility which provides day habilitation services for developmentally and intellectually delayed people who are twenty-one to ninety-five years old.

[redacted] 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], Justice Center Investigator II)

5. At the time of the alleged neglect, the Subject had been employed by the OPWDD as a Habilitation Specialist 1 (HS1) in [redacted] since 2011. (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 neglect, the Service Recipient was a forty-nine year old female with diagnoses of severe mental retardation and cerebral palsy with marked spasticity. (Justice Center Exhibit 17 and Hearing testimony of the Subject) The Service Recipient was non-verbal and non-ambulatory, and required the use of a wheelchair to move around. The Service Recipient had a history of disengaging her wheelchair brakes and propelling her wheelchair using her feet or hands. (Justice Center Exhibit 22: audio recording of Justice Center interrogations of Staff A, Staff D and the Subject; and Hearing testimonies of Staff C and the Subject)

7. When the Service Recipient was in the community, staff were required to provide her with arm's length supervision (ALS) in order to protect her safety. (Justice Center Exhibit 17)

8. On [redacted], the Subject was assigned with three other staff to [redacted] morning bowling outing with nine service recipients. Of the nine service recipients, three (including the Service Recipient) were non-ambulatory and remained in their wheelchairs for the duration of the outing. The Service Recipient and one other ambulatory service recipient required ALS while in the community. No specific staff was assigned to any specific service recipient on the outing. (Justice Center Exhibit 22: audio recording of Justice Center interrogations of Staff A, Staff B, Staff D and the Subject; and Hearing testimonies of Staff A, Staff B, Staff C and the Subject)

9. Once inside the entrance of the bowling alley, there was a ramp down to the hardwood approach[1] and the bowling lanes which were numbered in pairs starting with lanes one and two, and proceeding with lanes three and four, five and six, etc. Between each pair of lanes on the approach, were the ball returns which physically separated the approach. The approach extended behind each set of lanes, approximately three to four feet behind the ball returns. At the rear of the approach was a six inch drop-off, or step-down, to a recessed tile floor area which contained chairs, tables and the scoring computer controls. (Justice Center Exhibit 13 and Hearing testimonies of Staff A, Staff B and the Subject)

10. The bowling outings had been held [redacted] for at least ten years prior to the incident. [redacted] Staff's past practice had been to have the wheelchair-bound service recipients bowl in lane one in order to have their wheelchairs backed up against the end wall of the bowling alley when they were not bowling. On the [redacted] outing, lanes one and two were not in service. As a result, [redacted] staff decided to use lanes three, four and five, with the wheelchair-bound service recipients on lane three. (Justice Center Exhibit 13; Justice Center Exhibit 22: audio recording of Justice Center interrogations of Staff A, Staff B, Staff D and the Subject; and Hearing testimonies of Staff A, Staff B and the Subject)

11. After arriving at the bowling alley and getting prepared to bowl, the Subject took the three wheelchair-bound service recipients, including the Service Recipient, to lane three, Staff A took three of the ambulatory service recipients to lane four and Staff D took the remaining three ambulatory service recipients to lane five, and each staff assisted their respective service recipients with bowling. Staff B sat at the scoring table in the recessed tile floor area behind the lane

[1] The approach is the area of the bowling alley from the rear of the ball return area to the foul line.

three/four ball return and kept score for the service recipients bowling in lanes three and four. Staff B manipulated the scoring computer for the lane three service recipients so as to allow each wheelchair-bound service recipient to bowl two consecutive frames, thereby making it easier on the service recipients and the Subject, who was assisting them. (Justice Center Exhibit 22: audio recording of Justice Center interrogations of Staff A, Staff B, Staff D and the Subject; and Hearing testimonies of Staff A, Staff B and the Subject)

12. When the Subject was assisting one of the wheelchair-bound service recipients with bowling, she positioned the other two wheelchair-bound service recipients on the hardwood approach between lane three and lane two, roughly perpendicular to the lane, and engaged the service recipients' wheelchair brakes. While the Subject was assisting one of the wheelchair-bound service recipients, her back was turned to the other two service recipients and she was more than arm's length away from them. (Justice Center Exhibit 11; Justice Center Exhibit 22: audio recording of Justice Center interrogation of the Subject; and Hearing testimony of the Subject)

13. While the Subject was assisting one of the wheelchair-bound service recipients with bowling, while she was more than arm's length away from the Service Recipient, and while she had her back turned to the Service Recipient, the Service Recipient disengaged her wheelchair brakes and rolled backward at an angle over the edge of the hardwood approach. One of the rear wheels of the Service Recipient's wheelchair rolled over the edge and down six inches to the recessed tile floor area. As a result, the wheelchair tipped over causing the Service Recipient to fall to the floor and hit the back of her head on the tile floor. At the time this happened, Staff A was in lane four assisting an ambulatory service recipient who required ALS, Staff D was with three ambulatory service recipients away from the lanes in the shoe return area of the bowling alley, and Staff B was at the scoring table in the recessed tile floor area. (Justice Center Exhibits

9, 10, 11, 12 and 14; Justice Center Exhibit 22: audio recording of Justice Center interrogations of Staff A, Staff B, Staff D and the Subject; and Hearing testimonies of Staff A, Staff B and the Subject)

14. After the Service Recipient fell and hit her head, she was treated by emergency responders and airlifted to [redacted] Hospital in [redacted] where she was treated for a traumatic brain injury. At the hospital, the Service Recipient was diagnosed with a "small, right-sided subdural hematoma", a "small right frontal/right temporal contusion" and a "small left-sided middle cranial fossa extraaxial hemorrhage." (Justice Center Exhibit 18)

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 neglect.
- Pursuant to Social Services Law § 493(4), the category of 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) as:

> "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 neglect shall be categorized into categories pursuant to SSL § 493(4), including Category (2), which is defined as follows:

> (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.

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 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.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-22) The investigation underlying the substantiated report was conducted by [redacted], Justice Center Investigator II, who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented three other witnesses who testified on her behalf.

The facts surrounding the events of [redacted], are not in dispute.

In order to prove neglect, the Justice Center must prove by a preponderance of the evidence that the Subject breached a custodian's duty 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, because no specific staff was assigned to the care of any specific service recipient on the outing, all staff who were assigned to the outing had the duty to provide the correct level of supervision for all service recipients on the outing. The Justice Center further contends that the Subject had the duty to maintain ALS of the Service Recipient and breached her duty to the Service Recipient by failing to maintain ALS. The Subject does not contest that she assumed the duty of ALS for the Service Recipient, having assumed the duty of supervising and assisting the three wheelchair-bound service recipients with bowling in lane three.

However, the Subject contends that she did maintain ALS and that she understood ALS to mean staying within close proximity to the Service Recipient in order to assist the Service Recipient, and being aware of where the Service Recipient was at all times. The Subject further argues that she received no training on ALS and that there is no facility policy which defines ALS. (Hearing testimony of the Subject) The three staff who were assigned and went on the outing, and the Subject's supervisor, all support the Subject's argument, and there is no evidence in the record to the contrary. (Hearing testimonies of Staff A, Staff B, Staff D and Staff C)

There is conflicting evidence in the record concerning the meaning of ALS. (Hearing testimonies of Staff A, Staff B, Staff D and Staff C) However, the term contains little ambiguity. The plain meaning of the term indicates that staff must remain within a distance, equal to the length of staff's arm, of a service recipient who requires ALS. A further implication of the term, taken together with the Service Recipient's tendency to play with her wheelchair brakes and the reason for the prescription of ALS for the Service Recipient in this case (to protect the Service Recipient's safety), is that the staff must also maintain awareness of the Service Recipient's actions. In other words, Staff could not be found to have provided proper ALS having been within arm's length of the Service Recipient but having had his or her back turned to the Service Recipient.

The Subject admits to having been more than one arm's length away from the Service Recipient and to having had her back turned to the Service Recipient when the Service Recipient disengaged her wheelchair brakes and fell. The Subject testified that she did not notice the Service Recipient falling until she turned, from helping another service recipient, to get a ball and saw the Service Recipient going over the approach edge to the recessed tile floor area. (Justice Center Exhibit 22: audio recording of Justice Center interrogation of the Subject and Hearing testimony of the Subject) Consequently, the Justice Center has established that the Subject breached her duty

to maintain ALS of the Service Recipient.

The record reflects that the Service Recipient suffered a traumatic brain injury as a result of hitting her head on the floor while the Subject failed to maintain ALS. Consequently, the Justice Center has established that the Service Recipient sustained a physical injury as a result of the Subject's breach of duty.

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 of abuse or neglect set forth in the substantiated report. Category 2 conduct is defined as conduct in which the Subject seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b)) The Subject's conduct resulted in the Service Recipient falling in her wheelchair to a tile floor and hitting her head on the tile floor. The Service Recipient's injuries were serious enough to have her airlifted to the hospital. Finally, the Service Recipient was treated for a traumatic brain injury. These facts, taken together with the Service Recipient's developmental and physical disabilities, warrant a finding that the Service Recipient's health safety and welfare were seriously endangered as a result of the Subject's conduct. Therefore, 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.

A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2

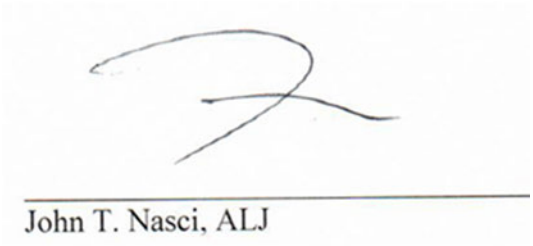
act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

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 neglect.

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

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

DATED: March 10, 2017
Schenectady, New York



John T. Nasci, ALJ