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]

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 physical abuse, neglect and abuse (obstruction of reports of reportable incidents).

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: June 7, 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 Jo Lattimore-Young
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
Delmar, New York 12054-1310
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By: Theresa Wells, Esq.

[redacted]

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/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 physical abuse and/or neglect when you put your hands behind a service recipient's neck and pulled her forward, causing her to suffer neck and back pain.

This allegation has been SUBSTANTIATED as Category 3 physical abuse and Category 3 neglect pursuant to Social Services Law §493(4)(c).

Allegation 2

It was alleged that on or about [redacted], during the course of an investigation of a reportable incident that occurred at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (obstruction of reports of reportable incidents) when you made false statements regarding an incident that involved a service recipient.

This allegation has been SUBSTANTIATED as Category 3 abuse (obstruction of reports of reportable incidents) 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, located at [redacted], is an Individualized Residential Alternative (IRA) for disabled persons, and is operated by [redacted], which is certified by the New York State Office for People With Developmental Disabilities (OPWDD). It is a facility or provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of the Director of Quality Improvement (QI Director) and Justice Center Exhibit 6)

5. At the time of the alleged abuse and neglect, the Service Recipient was a highly functional and verbal fifty-eight year old female who had been a resident of the facility since 2004. The Service Recipient was wheelchair bound due to her [redacted] left leg amputation. The Service Recipient's Individual Protective Oversight Plan (IPOP) required staff to use a Hoyer lift to transfer her from her wheelchair to her bed or to the shower chair. The Service Recipient also used a hospital bed with metallic rails on both sides. The Service Recipient had diagnoses of cerebral palsy and scoliosis as well as a history of depression. (Hearing testimony of the QI Director; Justice Center Exhibits 6 and 8-9)

6. At the time of the alleged abuse and neglect, the Subject had been employed by the facility since [redacted] 2015. The Subject was a Residential Habilitator, also referred to as a Direct Support Professional (DSP), whose job duties involved the day-to-day care of service recipients. (Hearing testimonies of the QI Director and the Subject)

7. On [redacted], the facility director informed the Subject that the Service Recipient was uncomfortable with how the Subject was transferring her using the Hoyer lift. The Service Recipient had requested that the Subject be retrained. The Subject had been initially

trained to operate the Hoyer lift sometime in [redacted]. (Hearing testimonies of the QI Director and the Subject; Justice Center Exhibit 6)

8. At approximately 9:00 p.m. on [redacted], Staff-1 and Staff-2 commenced the retraining of the Subject on how to use the Hoyer lift. During the retraining, the Subject incorrectly secured the Service Recipient to seat of the Hoyer lift such that the Service Recipient's body was off-centered and not properly positioned, resulting in her bottom "sagging" in the Hoyer lift sling. As a result, Staff-2 instructed the Subject to make an adjustment by lifting the Service Recipient. The Subject stood near the Service Recipient and attempted to make the adjustment by grabbing the back of the Service Recipient's neck in a fast and rough manner and pulling her forward. This action "scared" the Service Recipient. The Subject then lowered the Service Recipient's off-centered body onto her hospital bed using the Hoyer lift. While doing so, the Service Recipient's right foot hit the side rail of the bed. (Hearing testimony of QI Director; Justice Center Exhibits 6, 11-13)

9. On the following day, [redacted], the Service Recipient complained of pain in her neck and back. The on-call nurse was contacted by facility staff, told of the Service Recipient's pain and advised staff to ice the areas where the pain was occurring. The facility program manager performed a body check and found no visible injuries on the Service Recipient. (Justice Center Exhibit 10)

10. Thereafter, the Subject was interrogated on [redacted] as a part of the active investigation regarding the alleged [redacted] incident. At that time, the Subject reported to the investigator that she only observed the other staff conduct the Service Recipient's hoyer lift re-training. The Subject also reported to the investigator that she did not have her hands on the Service Recipient because she was not an active participant in the hoyer lift re-training, when in

fact, she was an active participant. (Justice Center Exhibit 14)

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 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 neglect of a person in a facility or provider agency is defined by SSL §§ 488(1)(a), (f) and (h), to include:

> (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.
>
> (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.
>
> (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 under § 493(4)(c) as follows:

> 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(s) 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/or 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/or neglect cited in the substantiated report constitutes the category of abuse and/or 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 established by a preponderance of the evidence that the Subject committed the acts, described as "Allegation 1" and "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 1-14) The investigation underlying the substantiated report was conducted by [redacted] ([redacted] Quality Improvement (QI) Investigator), who no longer works for the Agency. [redacted] ([redacted] QI Director) was the only witness who testified at the hearing on behalf of the Justice Center.

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

At the hearing, the Subject testified that at no time did she place her hands on the back of the Service Recipient's neck. The Subject also testified that her statements to the investigator during her interrogation that she did not touch the Service Recipient and that she had not actively participated in the Hoyer retraining, but that she had only observed Staff-1 and Staff-2 operate the Hoyer lift were all false. The Subject explained that she showered the Service Recipient first, then placed her hands on the Service Recipient when she attempted to transfer her onto the bed using the Hoyer lift. The Subject testified that, only after she had lowered the Service Recipient onto the bed using the Hoyer lift, Staff-1 and Staff-2 came into the room to assist and to retrain

her. The Subject testified that the Service Recipient did not appear to be uncomfortable while in the Hoyer lift. (Hearing testimony of the Subject)

The Subject testified further that, for several months prior to the incident, she had been using the Hoyer lift to assist other service recipients at the IRA. The Subject argued that she did not receive proper Hoyer lift re-training. The Subject also argued that it did not make sense that she would attempt to injure the Service Recipient with other staff in the room.

Because the Subject testified that she incorrectly told the investigator that she did not touch the Service Recipient or otherwise actively participate in the retraining, and that because her account of the incident differs substantially from the eyewitness accounts of Staff-1 and Staff-2, those portions of the Subject's written statement are not credited evidence.

Conversely, the Service Recipient (Justice Center Exhibit 11), Staff-1 (Justice Center Exhibit 12) and Staff-2 (Justice Center Exhibit 13) for the most part, corroborate each other's account of what happened, and their accounts of the incident are also consistent with their statements to the investigator. Consequently, the statements of the Service Recipient, Staff 1 and Staff 2 are credited evidence.

Allegation 1 – Physical Abuse

To prove physical abuse the Justice Center must first establish that the Subject's conduct was intentional or reckless. Such conduct is defined as including dragging. (SSL §488(1)(a)) The terms "intentional" and "reckless" are defined by Penal Law. (SSL §488(16) and PL 15.05(1) and (3)) The term "intentionally" is defined by Penal Law as follows: "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 in relevant part 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 evidence establishes that the Subject made physical contact with the Service Recipient. The evidence also establishes that the Subject's conduct was reckless. The Subject was upset because she was required to be retrained on operation of the Hoyer lift. During the retraining, the Subject used both of her hands to grab the Service Recipient behind her neck and quickly pulled her forward in a rough manner. The Subject was aware of the Service Recipient's age and frail physical condition. Nonetheless, the Subject disregarded her condition when she roughly moved the Service Recipient in the Hoyer lift. Because a reasonable person in the same situation would not have acted as the Subject did, the Subject's conduct constituted a substantial and unjustifiable risk of harm to the Service Recipient. Consequently, the Subject acted recklessly.

Because of the Service Recipient's frail physical condition, it is determined that the Subject's conduct caused the likelihood of physical injury and/or serious or protracted impairment of the physical, mental, or emotional condition of the Service Recipient. (SSL § 488(1)(a))

Allegation 1 – Neglect

In order to prove neglect, the Justice Center must establish that the Subject breached her 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))

Given the Service Recipient's age, scoliosis, leg amputation and other frailties, the Subject had a duty to appropriately handle her with care and ensure her safety. However, the Subject breached her duty by placing her hands on the back of the Service Recipient's neck, then quickly pulling her neck forward in a rough manner while the Service Recipient's body was unstable in the hoyer sling. The Subject's conduct caused the Service Recipient to be frightened and

experienced back and neck pain. (Hearing testimony of QI Director and Justice Center Exhibit 9)

Consequently, given all of the Service Recipient's frailties, the Subject's breach of duty was likely to have resulted in physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Allegation 2 –Abuse (obstruction of reports of reportable incidents)

In order to prove abuse (obstruction of reports of reportable incidents) as it was alleged in this report, the Justice Center must establish by a preponderance of the evidence that the Subject impeded the "... investigation of the treatment of a service recipient by ... intentionally making a false statement," (SSL §488(1)(f))

The evidence establishes that the Subject told the investigator several times during the Justice Center interrogation that, during her Hoyer lift retraining, she did not actively participate in the retraining but instead only watched Staff-1 and Staff-2 while they transferred the Service Recipient from her wheelchair to her bed. Yet, the Subject admitted at her hearing testimony that these statements that she had made to the investigator were false and that she actually did participate in the retraining. (Justice Center Exhibit 14)

The evidence establishes that the Justice Center's investigation was impeded by the Subject's conduct insofar as the false statements made by the Subject caused the investigator to re-direct and focus the investigation on the wrong staff persons (Staff-1 and Staff-2) and question their credibility in seeking the truth about the alleged incident.

The evidence also establishes that the Subject's failure to provide truthful information to the Justice Center investigator was intentional. The Subject admitted in her testimony that her statements to the investigator were false and thereafter provided a description of the incident that was more in line with that given by the Service Recipient and the two staff who were present.

Consequently, the Justice Center has established that the Subject has committed abuse (obstruction of reports of reportable incidents).

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 physical abuse, neglect and abuse (obstruction of reports of reportable incidents) 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 and 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 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], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed physical abuse, neglect and abuse (obstruction of reports of reportable incidents).

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

This decision is recommended by Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: June 2, 2017
Rochester, New York