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

In the Matter of the Appeal of [redacted]	**FINAL DETERMINATION AND ORDER AFTER HEARING**
Pursuant to § 494 of the Social Services Law	**Adjud. Case #:** [redacted]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

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: December 6, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Nathaniel K. Charny, Esq.

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: Louis P. Renzi
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
Eleanor Roosevelt State Office Bldg.
4 Burnett Blvd., 2nd Fl.
Poughkeepsie, New York 12601
On: [redacted]

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

[redacted]
By: Nathaniel K. Charny, Esq.
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9 West Market Street, Suite B
Rhinebeck, New York 12572

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 a wheelchair to transport a service recipient, during which time she fell.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

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

4. The facility, located at [redacted], is an Individualized Residential Alternative (IRA) home for up to fourteen developmentally disabled adults. It is operated by the NYS Office for People With Developmental Disabilities (OPWDD),

a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect (the incident), the Subject had been employed by OPWDD for approximately twenty years, with an unspecified break and return within that service. Her title at the time of the incident was Licensed Practical Nurse (LPN). Her duties involved both nursing functions and direct care functions. (Hearing testimony of the Subject)

6. At the time of the incident, [redacted], the Service Recipient was 60 years of age. The Service Recipient is an adult female with relevant diagnoses of profound intellectual disability, osteoporosis, cancer, Impulse Control Disorder, with significant visual impairment due to a detached retina and inoperative cataracts. The record is unclear as to how long the Service Recipient had been a resident of the facility. A review of her behavior support plans reveals an effective date of [redacted], while her day habilitation plan reflects an effective date of [redacted]; it is presumed that her residence tenure coincided with her day habilitation program. (Hearing testimony of Justice Center Investigator II [redacted] (Investigator [redacted]); Justice Center Exhibit 6, 15, 16, 17)

7. The Service Recipient's ability to ambulate was inconsistent, and she had a known tendency to allow herself to fall to the ground for suspected emotional and physical reasons when being taken to medical appointments. (Hearing testimony of Investigator [redacted]; Justice Center Exhibit 6) On [redacted], the Service Recipient fell and injured a finger. As a result, there was a discussion held between the Subject, Staff [redacted] (the Nurse), and Staff [redacted] (the House Manager) on or about that date, where these matters were discussed. The discussion resulted in a plan to utilize a wheelchair for all future outings with the Service Recipient, and that a prescription would be requested for the wheelchair. The prescription was obtained for a wheelchair on [redacted], the day before the incident. (Justice Center Exhibits 6, 22) The Subject admitted during her

interrogation that she had participated in the conversation and that she was aware of both the intent to use a wheelchair for the Service Recipient going forward and the plan to obtain a prescription. She also acknowledged that the Service Recipient was a known fall risk. (Justice Center Exhibits 6, 22) The Subject was assigned outside the facility on [redacted], and was unaware that the prescription had been written on the day before the incident. (Hearing testimony of the Subject; Justice Center Exhibits 6, 14)

8. On the day of the incident, the Subject was assigned to take the Service Recipient to the doctor. The Subject met Staff [redacted] (the house manager) and the Service Recipient at another location where the Subject received an agency van. (Hearing testimony of Investigator [redacted]; Justice Center Exhibit 6) The Subject then drove the Service Recipient to her doctor's appointment. There was a wheelchair in the back of the van. Upon arrival at the doctor's office, the Subject escorted the Service Recipient out of the van and did not use the wheelchair. While walking toward the office building, the Service Recipient stumbled and fell onto her knees. A passerby retrieved a wheelchair from the medical building at the request of the Subject. The Subject then wheeled the Service Recipient into the doctor's offices. (Hearing testimony of the Subject; Justice Center Exhibit 12)

9. The Service Recipient sustained physical injuries to her knees which were treated immediately. The following day it was discovered that she had a swollen and discolored left foot. She was transported to the emergency room and diagnosed with a fracture. It was determined to have been a result of the incident. (Hearing testimony of Investigator [redacted]; hearing testimony of the Subject; Justice Center Exhibits 6, 10, 11, 12, 13)

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 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) as:

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

> (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 neglect, described as "Allegation 1" in the substantiated report.

In order to prove an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that the Subject breached her duty, and that the breach either 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))

In support of its substantiated findings, the Justice Center presented several documents obtained during the investigation. (Justice Center Exhibits 1-19 and 22[1]) The investigation underlying the substantiated report was conducted by Investigator [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 Subject Exhibit A, a copy of a letter dated [redacted], with attachments, from the OPWDD Associate Director of Human Resources I Institution, which states that the Notice of Discipline (NOD) against the Subject had been dismissed. [2]

Specifically, the evidence established that the Subject was a custodian who owed a duty of care to the Service Recipient, which includes ensuring the health, safety and welfare of the Service Recipient. The Subject was an LPN, with approximately twenty years' experience. On the date in question, the Subject transported the Service Recipient to a medical appointment, fully aware that the Service Recipient was visually impaired, suffered from osteoporosis and other ailments, had a history of inconsistent ambulation and had fallen four days earlier, and had a documented habitual behavior of allowing herself to physically collapse when taken to such appointments. (Hearing testimony of the Subject) The evidence further established that the Subject failed to notice that she had a wheelchair available to her in the agency vehicle, and further that she failed to utilize that wheelchair to transport the Service Recipient safely from the vehicle to the medical office. The Service Recipient did "drop" or collapse while being escorted from the vehicle to the medical office building and struck her knees on the pavement or sidewalk, causing physical injuries which required medical attention. (Hearing testimony of the Subject; Justice Center

[1] Exhibits 20 and 21 were withdrawn by the Justice Center.
[2] Subject Exhibit A contains no arbitration decision or other explanation as to why the NOD was dismissed.

Exhibit 12) It was also discovered the following day that the Service Recipient had significant swelling and discoloration to her left foot and was taken to the emergency room for diagnosis and treatment. It was found to be fractured, and it was concluded that the fracture was a result of the fall suffered while in the Subject's care. (Hearing testimony of Investigator [redacted]; hearing testimony of the Subject; Justice Center Exhibits 6, 11, 12, 13, 22)

During her testimony, the Subject acknowledged that she was aware of the plan for using the wheelchair, and the intent to obtain a prescription. The Subject denied receiving any supervisory directives requiring the use of a wheelchair for the Service Recipient prior to the incident. She further stated that since the prescription had not yet been issued to her knowledge, she was not required to use the wheelchair for the Service Recipient. Her statements are controverted by the recorded statements of Staff [redacted] and Staff [redacted], which are credited evidence. (Justice Center Exhibit 22) The portion of the Subject's testimony described above is inconsistent with admissions she had made during her interrogation. (Justice Center Exhibits 6, 22) The Subject's testimony was clearly self-serving, and, under these facts, is not credited.

Given the diagnoses and the behavioral tendencies of the Service Recipient, all of which were admittedly known by the Subject, it is very difficult to understand why the Subject's training and common sense would not guide her to utilize a wheelchair to transport the Service Recipient, without the need for a specific directive from supervisory staff or the mandate of a prescription. Instead, the Subject ignored the reality of the Service Recipient's infirmities. The Subject's theory also defies logic, and no evidence in this record other than her own testimony supports the notion that a prescription is required before taking a safety precaution that is clearly necessary, as was the case here.

Secondly, common sense would further dictate that the Subject would pay attention to the

fact that the chair was in the van with her. The evidence indicates that commonly, while the chair may not have been visible to the driver, it moves somewhat while the van is underway and the noise could be heard by staff in the van. (Justice Center Exhibit 6, page 014) Even if that were not true, at the very least the Subject should have recognized the need for a wheelchair and looked to see if it was there, and if not, should have obtained one before attempting to transport the Service Recipient to the medical building.

Thus, it is concluded that the Subject breached the duty of care she owed to the Service Recipient.

Finally, it is uncontroverted on this record that the Service Recipient sustained serious physical injuries – abrasions and a fractured foot – caused by the Subject's breach of her 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. 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 Louis P. Renzi, Administrative Hearings Unit.

DATED: November 22, 2017
Schenectady, New York

Louis P. Renzi, ALJ