

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AND ORDER  
AFTER HEARING**

**Adjud. Case #:**

[REDACTED]

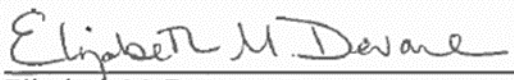
The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

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 Elizabeth M. Devane, ALJ, Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

**Dated: September 26, 2018**  
Schenectady, New York

  
Elizabeth M. Devane  
Administrative Law Judge

CC. Vulnerable Persons' Central Register  
Administrative Appeals Unit  
[REDACTED], Subject  
Bethany K. Hurteau, Esq.

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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

[REDACTED]

Before:

Gerard D. Serlin  
Administrative Law Judge

Held at:

Administrative Hearings Unit  
New York State Justice Center for the Protection  
of People with Special Needs  
New York State Office Building  
333 East Washington Street - Room 115  
Syracuse, New York 13202  
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: Bethany K. Hurteau, Esq.  
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143 Washington Avenue  
Capitol Station Box 7125  
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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] 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 a custodian, you committed neglect when you failed to ensure that the commode chair that a service recipient was sitting on during toileting was properly secured to the wall, during which time she fell to the floor and sustained a contusion.

This allegation has been SUBSTANTIATED as 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 residence for people with 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 the Justice Center Investigator)

5. At the time of the alleged neglect, the Subject was employed by OPWDD as a direct support staff on a part time basis and had been employed by OPWDD at the facility for three years.

(Hearing testimony of the Subject) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was a female, fifty-one years of age, and had been a resident of the facility for approximately seven years. The Service Recipient was nonverbal and largely confined to a wheelchair that she was able to self-propel. The Service Recipient was required to wear a gait belt and helmet when transferring from a seated position to nearby locations. (Justice Center Exhibit 8)

7. The Service Recipient's toileting protocol was outlined, in part, in her Individual Service Plan (ISP) follows:

Needs staff assistance to the bathroom every two hours. Contact guard to minimal assistance on her gait belt to transfer the commode chair that is secured to the wall, with tray and seatbelt, MUST have protective helmet on and fastened properly prior to transfers. She may have her helmet removed while on the commode chair. Staff provides visual checks every 5 minutes. [Service Recipient] will respond with Yes/No or gesture if she has used the toilet. The Day Hab site Staff provides constant visual supervision when on the toilet. (Justice Center Exhibit 14, Bates stamp p. 50)

8. The Service Recipient's "daily routine" plan, (Justice Center Exhibit 15, Bates stamp p. 054) required that staff "... check the condition of the commode chair, tray and clips daily to ensure that all are in working order." While the Subject had received training in proper use of the portable commode assist device, she was not familiar with the Subject's daily routine plan. (Hearing testimony of the Subject)

9. In the weeks leading up to the date of the incident, the Facility supervisor had instituted new cleaning procedures for the Facility bathroom which required that, daily, the portable commode assist device be moved away from the wall and the toilet, to facilitate toilet cleaning by staff working the overnight shift. The Subject learned of this directive sometime during the month of [REDACTED], when she read the Facility log. (Hearing testimony of the Subject)

10. The portable commode assist device had four legs and a desk type tray. The portable commode assist device was stationed over the toilet bowl. The Service Recipient was seated on the toilet, and the hinged desk type tray was positioned in front of the Service Recipient, to keep the Service Recipient from falling forward, or to the side. (See Justice Center Exhibit 25a)

11. The portable commode assist device had straps on the two rear legs which were buckled to another strap that was permanently fastened, with screws, to the baseboard along the bathroom wall. The strap could be unbuckled at a point between the anchor point on the wall and the leg of the portable commode assist device. There were two anchors in the system, one at the rear left leg and one at the rear right leg of the portable commode assist device. (Justice Center Exhibit 25c and Hearing testimonies of the Subject and the Justice Center Investigator)

12. Prior to the incident underlying the report, the Subject had toileted the Service Recipient and another service recipient earlier in the day, without incident. Subsequently, approximately 2:50 p.m., on [REDACTED], just before the Subject's shift was to end, the Subject placed the Service Recipient on the toilet using the portable commode assist device. At that time the Subject did not confirm, by tugging or pulling, that the anchor point straps were securely affixed to the wall. The Subject assumed that the anchor points were appropriately affixed and that the buckles were properly clasped based upon her visual observation of them. (Hearing testimony of the Subject)

13. The Subject exited the bathroom and communicated to other staff in the Facility that the Service Recipient was toileting. (Hearing testimony of the Subject) The Subject then left the Facility for the day, as her shift had come to an end. Shortly thereafter, the Service Recipient fell or tipped over the portable commode assist device. During her fall, the Service Recipient remained strapped into the portable commode assist device. (Hearing testimony of the Justice Center Investigator) When Facility staff heard the noise made by the Service Recipient's fall, they responded to the bathroom and observed that the Service Recipient was tipped over in the portable commode assist device. The desk type tray was properly deployed in the upright position and the anchor point buckles, which were designed to secure the commode assist device, were not secured. (Hearing testimony of the Justice Center Investigator)

14. Because of the fall, the Service Recipient sustained a facial contusion and a minor injury to her elbow. She was transported to and evaluated at the hospital. (Hearing testimony of the Justice Center Investigator)

### **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), as follows:

(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 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 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 and photographs obtained during the investigation. (Justice Center Exhibits 1 -23, 25 and 26) The Justice Center also presented audio recordings of the Justice Center Investigator’s interview of witnesses and interrogation of the Subject. (Justice Center Exhibit 26) The investigation underlying the substantiated report was conducted by Justice Center Investigator [REDACTED], who testified at the hearing on behalf of the Justice Center. The Subject testified in her own behalf.

The Justice Center’s theory was that the Subject failed to ensure that the Service Recipient’s portable commode assist device was properly affixed to the wall when the Subject assisted the Service Recipient into position on the toilet, and that this failure was a breach of the Subject’s duty. Because of this alleged breach, the Justice Center alleges that the Service Recipient fell and sustained minor physical injuries.

A preliminary issue raised by the Subject was that she was not assigned to the Service



Recipient on the date at issue, and therefore she had no duty to the Service Recipient. The Subject testified that her supervisor had been assigned to care of the Service Recipient on that date. Irrespective of this argument, it is undisputed in the record that the Subject, a custodian, assisted the Service Recipient with toileting; therefore, she had a duty to perform that task in a manner consistent with generally accepted standards and as any other reasonably prudent staff person would.

Largely, there was little factual dispute on the remaining issues. Shortly before the incident, a new House Manager had initiated vigorous cleaning procedures for the Facility. As a result, each evening during the overnight, staff unfastened the commode assist device from the wall anchors to effectuate cleaning of the toilet and surrounding area. The Subject was aware of this practice and, on the date in question, she failed to ascertain, by tugging or pulling the anchor, if the anchor was secured appropriately to the wall. Instead, the Subject noted that, from visual observation, the buckles appeared intact and to be secured.

When interviewed, the Subject told the investigator that she had toileted the Service Recipient and other service recipients earlier on the same date as the incident, and that each time she had confirmed that the portable commode assist device was fastened to the wall. Those instances of toileting were uneventful. (Hearing testimony of the Justice Center Investigator) The Subject testified that, at the time of the incident, she had assumed that the anchor points were appropriately affixed because, upon visual inspection, she observed the buckles to be clasped.

During the course of the investigation, the Justice Center Investigator asked other staff whether they believed it was possible that the Service Recipient could have, on her own, accidentally unclasped the buckles which secured the commode assist device to the wall. The Justice Center Investigator testified that, as an investigatory tool, she positioned herself on the toilet and strapped

herself in with the commode assist device with the desk type tray deployed. She then attempted to unclasp the buckle, of which there were two, one on each leg of the device, but the Investigator found that she could not reach around to do so with desk type tray deployed. (Hearing testimony of the Justice Center Investigator) During the interrogation, the Subject expressed that she did not believe that the Service Recipient could unbuckle the anchor on her own. (Justice Center Exhibit 26) The Justice Center Investigator did interview the Service Recipient during the investigation, but the Service Recipient was non-verbal and unable to meaningfully assist in the investigation. (Hearing testimony of the Justice Center Investigator)

At least one staff told the Investigator that, if the Service Recipient had a behavioral outburst, she may have unclasp the buckle, (Hearing testimony of the Justice Center Investigator) and, in her hearing testimony, the Subject speculated that, although the two buckles had appeared to her to be fully engaged, the staff who cleaned the toilet may have left the buckles less than completely engaged, causing a situation where the buckles could break free easily. The Subject reached this conclusion based upon experimentation she conducted after the event. (Hearing testimony of the Subject)

On cross-examination, the Subject confirmed that she conducted a visual only inspection of the anchor-buckle system, and that she did not pull on the straps to confirm that they were appropriately secured. The Subject then explained the similar process of securing wheel chairs in the Facility van, and that she would routinely shake the wheel chair to ensure that the wheelchair was properly attached. Clearly, the Subject was familiar with the technique of pulling on straps or other objects to confirm that they were secure.

The Subject testified that the toileting process, in which she had been instructed, was meant to ensure that the Service Recipient was lap-belted into the portable commode assist device, that

she was wearing a helmet during transitions and that the desk type tray was deployed. The Subject testified that she learned of this procedure through on-the-job training, and in a separate training which was documented in her file but not part of the evidence gathered during the investigation. The Subject testified that she had, at the time of the incident, been familiar with and had access to the Service Recipient's ISP. (See Justice Center Exhibit 14)

The Subject also testified that she had not been instructed in the process set forth in, and was not familiar with, the Service Recipient's daily routine log. (Justice Center Exhibit 15) Essentially, the Subject took the position that she was unaware that Facility staff were required "to check the condition of the commode chair, tray and clips daily to ensure that they are in working order." (Justice Center Exhibit 14, Bates stamp 054)

Any reasonably prudent staff person in the Subject's position, knowing that the night staff had unbuckled the straps to facilitate cleaning, would test the buckles by tugging at them to ensure they were properly engaged each time the chair was used.

Therefore, the Subject had a duty to ensure that the straps/buckles were appropriately locked in place by physically testing them. This duty existed independently of the instructions found in the Service Recipient's daily routine log. (Justice Center Exhibit 15)

The Subject's attorney argued that there is no direct evidence as to how the Service Recipient tipped over. From interviews with staff, the Justice Center Investigator concluded and testified that the entire portable commode assist device was on its side, and the Service Recipient was strapped in, when she was found. After considering all the evidence, the only logical explanation for this fall is that either both anchor point buckles broke or became damaged during a behavioral outburst by the Service Recipient or, in the alternative, that the buckles had been left incompletely clasped by Facility staff, and were therefore easily unclasped when the Service

Recipient moved.

There was no evidence that the anchor system was determined to be broken after the Service Recipient fell and, based upon the Investigator's experiment, it is improbable that the Service Recipient could have unclasped the buckles herself. The most probable explanation is the one provided by the Subject herself, that while the buckles appeared to be fastened upon visual inspection, they were not actually fastened.

The Subject had a duty to ensure that the straps/buckles of the portable commode assist device were appropriately locked in place by physically testing them when she toileted the Service Recipient, and the Subject breached this duty. As a result of the Subject's breach of duty, the Service Recipient tipped over the portable commode assist device and fell to the floor, wherein she sustained physical injuries. 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 and sealed.

The next question to be decided is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. After considering all of the evidence, the report is appropriately categorized as Category 3 neglect.

Substantiated Category 3 findings of 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.

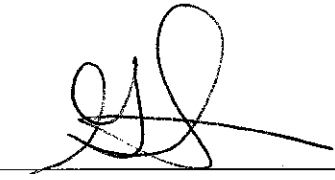
**DECISION:**

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 neglect.

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

This decision is recommended by Gerard D. Serlin, Administrative Hearings Unit.

**DATED:** August 1, 2018  
Schenectady, New York

  
Gerard D. Serlin  
Administrative Law Judge