

**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, of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: August 28, 2020  
Schenectady, New York



Elizabeth M. Devane, Esq.  
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register  
Kevin McGuckin, Esq.  
[REDACTED], Subject  
Richard Washington, 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:

Susanna Requets  
Administrative Law Judge

Held at:

Video Conference Hearing  
Administrative Hearings Unit  
New York State Justice Center for the Protection  
of People with Special Needs  
9 Bond Street – 3<sup>rd</sup> Floor  
Brooklyn, New York 11201  
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: Kevin McGuckin, Esq.

[REDACTED]

By: Richard Washington, Esq.  
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100 Church Street, Suite 800  
New York, New York 10007

### **JURISDICTION**

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for physical 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 physical 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 1**

It was alleged that on or about [REDACTED], while away from [REDACTED], located at [REDACTED], you committed Neglect against/to a Service Recipient.

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

The investigation revealed the Subject dragged the Service Recipient on the floor by her legs.

#### **Allegation 2**

It was alleged that on or about [REDACTED], while away from [REDACTED], located at [REDACTED], you committed Physical Abuse against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 3 Physical Abuse pursuant to Social Services Law § 493(4)(c).

The investigation revealed the Subject dragged the Service Recipient on the floor by her legs.

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) operated by [REDACTED] and certified 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 OPWDD Office of Investigations and Internal Affairs Investigator [REDACTED] (Investigator); Justice Center Exhibit 24)

5. At the time of the alleged physical abuse and neglect, the Subject was employed by [REDACTED] as a Direct Support Professional (DSP) and had been a part-time employee of the facility for one year and two months. The Subject was trained on the Service Recipient's plans for food, self-injurious behavior and diagnoses. (Hearing testimony of the Subject; Justice Center Exhibit 33: audio recording of interrogation 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 physical abuse and neglect, the Service Recipient was sixty-seven years old and had been a resident of the facility for more than thirty years. The Service Recipient was an adult female with relevant diagnoses of moderate intellectual disability, seizure disorder, atypical psychosis, schizophrenia, age-related osteoporosis, and unilateral primary osteoarthritis of the left knee. The Service Recipient required a wheelchair as a result of her unsteady gait and limitations in mobility. (Justice Center Exhibits 6, 22, 24 and 25)

7. On [REDACTED], the Service Recipient fell from her bed and hurt her left knee. The Service Recipient continued to have persistent left leg swelling and pain and was admitted to [REDACTED] Medical Center for cellulitis on [REDACTED]. On [REDACTED], the Service Recipient was transferred to [REDACTED] (Nursing Home) for rehabilitation. [REDACTED] provided 1:1 staffing for the Service Recipient at the Nursing Home. (Justice Center Exhibits 6, 8, 12, 21, 22 and 23)

8. Upon entering the Service Recipient's room in the Nursing Home, the bathroom was on the right, followed by the Service Recipient's bed. There was space on both the right and left side of the bed. On the far side of the room toward the window was a second bed with an individual who was unable to communicate. (Justice Center Exhibits 6, 15, 16 and 33: audio recording of interrogation of the Subject)

9. The Subject was assigned to the Service Recipient on [REDACTED], from [REDACTED]. At approximately 11:30 a.m., the Service Recipient sat in a wheelchair on the left side of her bed and the Subject sat on the other side of the Service Recipient's bed next to the bathroom facing the Service Recipient. The Service Recipient wanted to lay in her bed, but the nursing staff told the Subject that it was too early for the Service Recipient to lay in bed. Consequently, the Service Recipient remained seated in her wheelchair. At some point, the Subject observed the Service Recipient sliding down the wheelchair and stretching her feet. The Subject went to the Service Recipient and was able to get the Service Recipient back to a seated position on the wheelchair. (Justice Center Exhibits 6, 15 and 33: audio recording of interrogation of the Subject)

10. A few minutes later, at approximately 11:36 a.m., the Service Recipient slid down the wheelchair a second time. This time, the Service Recipient slid off the wheelchair with her

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buttocks resting on the foot pads. The Subject, facing the Service Recipient, tried to lift the Service Recipient back on the wheelchair. (Justice Center Exhibit 15) The Service Recipient yelled “stop.” Certified Nursing Assistant 1 (CNA 1<sup>1</sup>) and Licensed Practical Nurse (LPN 1<sup>2</sup>) were in the room directly across the hallway changing the dressing of another individual and overheard the commotion. As they opened the door and entered the room, the Subject dragged and pulled the Service Recipient approximately six inches as the Service Recipient sat on the floor on her buttocks with her back in front of the wheelchair. The Subject’s left hand held the Service Recipient’s right calf and the Subject’s right hand held the Service Recipient’s left calf. LPN 1 told the Subject to “stop.” (Hearing testimonies of LPN 1 and the Subject; Justice Center Exhibits 10, 14, 15 and 33: audio recording of interviews of CNA 1 and LPN 1)

11. The Subject noticed LPN 1 and CNA 1 and said, “come and give me a fuckin (sic) hand.” LPN 1 tried to explain that when a patient is on the floor, the Nursing Home policy was to call the supervisor and assess the patient prior to picking the patient up from the floor. Since the nursing staff did not know what injuries, if any, the Service Recipient sustained, an assessment to ensure the Service Recipient did not have any injuries and was not having difficulty breathing was required prior to picking the Service Recipient up from the floor. The Subject responded with expletives calling LPN 1 a “bitch” and demanding that LPN 1 help pick the Service Recipient up from the floor and place her back on the wheelchair. LPN 1 left the room to contact the RN Supervisor (Supervisor<sup>3</sup>). (Hearing testimony of LPN 1; Justice Center Exhibits 9, 14, 17 and 33: audio recording of interviews of CNA 1 and LPN 1)

12. The Supervisor came and tried to explain the policy to the Subject, but again the

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<sup>1</sup> CNA 1 was ██████████.  
<sup>2</sup> LPN 1 was ██████████.  
<sup>3</sup> The Supervisor was ██████████.

Subject continued to yell at the Supervisor and LPN 1. The Subject called LPN 1 a “dumb bitch nurse,” the nurses “fuckin stupid” for not wanting to pick the Service Recipient up from the floor, and threatened to file a complaint against the nursing staff for not assisting her with picking the Service Recipient up from the floor. (Justice Center Exhibits 9, 12, 14, 15, and 33: audio recording of interviews of LPN 1 and Supervisor) After consulting with the Director of Nursing (Director<sup>4</sup>), the Supervisor told the Subject and called the IRA Manager<sup>5</sup> explaining that the Subject had to leave because of the reported verbal and physical abuse. During this period, the Subject also called the IRA Manager two times to complain about the lack of nursing assistance and being asked to leave the Nursing Home. The nursing staff picked the Service Recipient up from the floor and the Subject left. (Hearing testimonies of the Subject, LPN 1 and IRA Manager; Justice Center Exhibits 9, 13, 17 and 33: audio recording of interrogation of the Subject and interview of the Supervisor)

13. Doctor 1<sup>6</sup> evaluated the Service Recipient and found no bruising, no discoloration and no changes in her range of motion. In addition, the results of an x-ray of the Service Recipient’s pelvis and knee were negative. (Justice Center Exhibit 12)

### ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the 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 acts constitute.

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<sup>4</sup> The Director was [REDACTED].

<sup>5</sup> The IRA Manager was [REDACTED].

<sup>6</sup> Doctor 1 was [REDACTED].

### **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 report of physical 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...” (14 NYCRR § 700.3(f))

The physical abuse and neglect of a person in a facility or provider agency are defined by SSL § 488(1), as follows:

- (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 physical abuse and 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 acts of physical abuse and neglect alleged in the substantiated report that is the subject of the proceeding and that such acts constitute the category of abuse and neglect as set forth in the substantiated report. (14 NYCRR § 700.10(d))

If the Justice Center proves the alleged physical abuse and neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and 14 NYCRR § 700.10(d), it must then be determined whether the acts of physical abuse and neglect cited in the substantiated report constitute the category of abuse and neglect as set forth in the substantiated report.

If the Justice Center did not prove the physical 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 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 through 32) The Justice Center also presented audio recordings of the Investigator’s interview of witnesses and the Subject. (Justice Center Exhibit 33) The investigation underlying the substantiated report was conducted by the Investigator, who testified at the hearing on behalf of the Justice Center. LPN 1 also testified on

behalf of the Justice Center.

The Subject testified in her own behalf. The IRA Manager also testified on the Subject's behalf.

The Justice Center alleged that the Subject dragged and/or pulled the Service Recipient by her legs, which constituted both physical abuse and neglect. The Justice Center relied on LPN 1's firsthand account of what transpired in the Service Recipient's room on [REDACTED] and alleged that the Subject inappropriately attempted to pick the Service Recipient from the floor by grabbing and pulling her legs. (Hearing testimony of LPN 1; Justice Center Exhibits 14 and 33: audio recording of interview of LPN 1) The Justice Center further alleged that dragging constituted physical abuse, regardless of the distance dragged, and that such conduct was not reasonable and was a breach of the Subject's duty to the Service Recipient.

The Subject adamantly denied that she ever touched the Service Recipient's legs. The Subject testified that the door to the room was kept open at all the times, that the Service Recipient slid from the wheelchair two times, and that she put her arms under the Service Recipient's arms and her legs between the Service Recipient's legs to ease the Service Recipient gently on the floor. The Subject remained in that position and called out for help from LPN 1 who was passing in the hallway. The Subject testified that LPN 1 was on her phone, did not come inside the room, and LPN 1 told the Subject that she had to call the Supervisor. After easing the Service Recipient onto the floor, the Subject testified that she was unable to lift the Service Recipient because she was "dead weight." According to the Subject, instead of assisting, the nursing home staff allowed the Service Recipient to sit on the floor for twenty-four minutes. (Hearing testimony of the Subject)

The Subject further alleged that LPN 1 fabricated the allegations as retaliation for her complaint against the Nursing Home staff's lack of assistance. The Subject contended that it is

not credible that LPN 1 heard a scream from across the room if the door was closed, that the Supervisor did not arrive immediately upon LPN 1's request, that LPN 1's testimony that the Service Recipient was dragged six inches is inconsistent with her drawing showing the Service Recipient was dragged toward the door, and that there is no bruising or discoloration to corroborate that the Service Recipient was dragged or pulled across the floor. (Hearing testimony of the Subject; Justice Center Exhibits 15, 33: audio recording of interrogation of the Subject and interview of LPN 1)

The Administrative Law Judge presiding over the hearing, having observed and evaluated the hearing testimony of the Subject on this material issue, does not find the Subject's testimony to be credible in contrast to the testimony of LPN 1. The Subject denied touching the Service Recipient's legs. During her interrogation, the Subject said that she was trying to get the Service Recipient's feet/heels steady on the ground to get her back in the wheelchair, but the Service Recipient could not lift her legs. (Hearing testimony of the Subject; Justice Center Exhibits 6 and 33: audio recording of interrogation of the Subject)

LPN 1's hearing testimony was consistent with her written statement, a recorded interview statement with the Investigator and her conversation with the Supervisor. (Hearing testimony of LPN 1; Justice Center Exhibits 10, 12, 13, 14 and 33: audio recording of interviews of LPN 1 and Supervisor) The Investigator never asked LPN 1 how far the Subject dragged the Service Recipient and never asked LPN 1 to clarify LPN 1's drawing of the room. (Hearing testimony of the Investigator; Justice Center Exhibits 15 and 33: audio recording of interview of LPN 1) Furthermore, the touching and pulling of the Service Recipient's leg was corroborated by CNA 1 in her investigatory interview, although CNA 1 did not include such observation in her written statement. (Justice Center Exhibits 10 and 33: audio recording of interview of CNA 1) There is

no evidence that LPN 1 or any of the nursing staff sought to retaliate against the Subject. LPN 1 informed the Supervisor that she saw the Subject pull the Service Recipient by her legs when she contacted the Supervisor to assess the Service Recipient. (Justice Center Exhibits 13 and 33: audio recording of interview of the Supervisor) The retaliation argument is not given any weight in view of LPN 1's multiple consistent statements on [REDACTED], that were provided without an opportunity to collaborate with other staff. (Hearing testimony of LPN 1; Justice Center Exhibits 10, 12, 13, 14 and 33: audio recording of interview of LPN 1)

After giving due consideration to the evidence in the record, it is determined that substantial weight must be given to the more logical, credible, reasonable and consistent statements of LPN 1 as compared to the self-interested statements of the Subject.

#### **Allegation 1 - Neglect**

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject's action, inaction or lack of attention breached a 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))

As set forth above, the credible evidence demonstrates that the Subject dragged and pulled the Service Recipient's legs. As a custodian, the Subject had a duty of care to support the well-being of the Service Recipient, including protecting the safety and health of the Service Recipient, knowing her behavior and diagnoses and supporting her rehabilitation. The Subject breached her professional duty as a DSP when she improperly maneuvered the Service Recipient by grabbing and pulling her legs. The Subject testified that two to three staff were needed to lift and/or transfer the Service Recipient in the IRA. Yet, on [REDACTED], the Subject attempted to independently move the Service Recipient instead of waiting for assistance and did so by

improperly grabbing and pulling the Service Recipient by her legs. (Hearing testimony of LPN 1; Justice Center Exhibit 33: audio recording of interview of LPN 1) The Subject's solo attempt to lift or move the Service Recipient while knowing that she was unable to do so was likely to result in physical injury, considering the Service Recipient's age, diagnoses of osteoporosis and osteoarthritis, as well as being in the Nursing Home for rehabilitation of her left knee. (Justice Center Exhibits 6, 22, 24 and 25)

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.

### **Allegation 2 – Physical Abuse**

In order to sustain an allegation of physical abuse in this matter, the Justice Center must show that the Subject had physical contact with the Service Recipient; that such contact was either intentional or reckless; and that such contact caused either physical injury or serious or protracted impairment of a Service Recipient's physical, mental or emotional condition; or caused the likelihood of such injury or impairment. Dragging is included in the definition of physical abuse. The statute allows, as an exception, the use of physical contact as a reasonable emergency intervention necessary to protect the safety of any person. (SSL § 488[1][a])

Social Services Law defines "intentionally" and "recklessly" as having the same meaning as provided in New York Penal Law § 15.05. (SSL § 488[16]) Under the New York Penal Law, a person acts "intentionally" with respect to a result or conduct when a person has a "... conscious objective ..." to cause a result or engage in such conduct. (PL § 15.05[1]) Under the New York Penal Law, a person acts "recklessly with respect to a result or to a circumstance" when the person is "aware of and consciously disregards a substantial and unjustifiable risk that such result will

occur or that such circumstances 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 credible evidence establishes that the Subject made physical contact with the Service Recipient by intentionally and recklessly dragging the Service Recipient’s legs. The Subject consciously disregarded the substantial and unjustifiable risk of dragging a Service Recipient who is elderly, has osteoporosis and osteoarthritis as well as cellulitis on the left knee and was admitted to the Nursing Home for rehabilitation. (Justice Center Exhibit 33: audio recording of interview of LPN 1 and CNA 1) LPN 1 testified that two to three people were needed to transfer the Service Recipient in order to properly protect the Service Recipient’s waist and head. (Hearing testimony of LPN 1) The Subject testified that if she had to lift the Service Recipient in the facility, she would request assistance because she could not do it by herself. (Hearing testimony of the Subject) The preponderance of the evidence shows that the Subject's intentional and reckless conduct of dragging the Service Recipient, even a few inches, to pick her up and/or or move her by herself caused the likelihood of a physical injury. (Hearing testimony of LPN 1) The Subject denied touching the Service Recipient’s legs and did not argue that her conduct was a qualified exception as a reasonable emergency intervention necessary to protect the safety of any person under Social Services Law § 488(1)(a).

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 alleged. The substantiated report will not be amended and sealed.

Since 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 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 and neglect.

The substantiated report is properly categorized as Category 3 acts.

This decision is recommended by Susanna Requets, Administrative Hearings Unit.

**DATED:** August 20, 2020  
Brooklyn, New York

  
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Susanna Requets, ALJ