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

In the Matter of the Appeal of

Pursuant to § 494 of the Social Services Law

FINAL DETERMINATION AND ORDER AFTER HEARING
Adjud. Case #: 521091641

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: January 8, 2020
Schenectady, New York

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Kristin Kopach, Esq.
[redacted], Subject
Russell Wheeler, 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 #: 521091641

Before: Keely D. Parr
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
4 Burnett Boulevard
Poughkeepsie, New York 12603
On: October 10 and 21, 2019

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

[redacted] Subject
[redacted]

By: Russell Wheeler, Esq.
Charny & Wheeler
9 W Market Street
Rhinebeck, NY 12572-1402

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 December 13, 2018 (VPCR Master Case # 551088015), 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 or about October 9, 2018, in the agency vehicle away from the Mid-Hudson IRA, located at 50B Leonard Street, Middletown, New York, while a custodian, you committed neglect when you failed to properly secure a service recipient in the vehicle.
>
> 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, located at 50B Leonard Street, Middletown, New York, is an individualized residential alternative (IRA) operated by the Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice

Center.

5. On the date of the alleged neglect, the Subject was employed by OPWDD for approximately ten years and worked at the IRA as a Direct Support Assistant (DSA). The Subject spent the majority of her career on the night shift and transitioned to the day shift on April 15, 2018, where she began driving the agency vehicle. The Subject received Q'Straint Tie Down training in June of 2015 but did not receive any additional formal training when she began transporting service recipients in April of 2018, including the Service Recipient. (Hearing Testimony of Subject; Justice Center Exhibit 27)

6. On the date of the alleged neglect, the Service Recipient was a 63-year old male, functioning in the profound range of intellectual disability. The Service Recipient used a wheelchair with a lap tray and seatbelt for all of his transportation and mobility needs due to his diagnosis of cerebral palsy. The Service Recipient required 24-hour supervision with general awareness of his whereabouts. (Justice Center Exhibit 21)

7. On October 9, 2018, the Subject drove the Service Recipient in the agency vehicle along with five other service recipients to the day habilitation program. The Subject secured the Service Recipient in his wheelchair in the agency vehicle and ensured that it could not move. The Subject was the only staff member in the vehicle. From time to time, the Subject looked in the rearview mirror and was able to see the Service Recipient. Upon arrival at the day habilitation program, Staff #1[1] motioned to the Subject as she was parking. The Subject came out of the vehicle and around the back and saw that the Service Recipient's wheelchair had tipped to the right with the Service Recipient still strapped in the wheelchair. The Subject righted the Service Recipient and Staff #1 called the nurse[2]. (Hearing Testimony of Subject; Justice Center Exhibit

---

[1] Chambers

[2]

36)

8. The nurse examined the Service Recipient, noted a small reddened area along his right rib cage, and instructed the Subject to take him to urgent care, which she did. Urgent care did not find any injuries, however placed the Service Recipient on a mild concussion protocol, as the Subject was not sure whether the Service Recipient had hit his head when he fell. (Hearing Testimony of Subject; Justice Center Exhibits 13, 18 and 36)

9. On October 10, 2018, the Subject was sent to the day habilitation program where a certified occupational therapy assistant[3] (COTA) instructed staff on how to tie down the wheelchair and demonstrated how to use the Q'Straint System. In addition, the Subject watched the video entitled "QSTRAINT QRTMAX Restraint System Training Program" which detailed how to use this system to ensure that passengers are secured in their wheelchairs while traveling in vehicles. While the COTA was inspecting the agency vehicle, it was necessary for her to remove the Q'Straint retractors with a hammer in order to detach them from the anchor. The COTA removed all of the Q'Straint components, including the refractors and hooks as they were in the wrong places and needed to be cleaned. (Hearing Testimony of Subject, Staff #3 and Staff #4; Justice Center Exhibits 14, 37 and 38; Subject Exhibit B)

10. On the date of the alleged neglect, the van that the Subject was driving did not belong to the agency but was on loan from another facility. No in-service training was provided to the Subject specific to this van. (Justice Center Exhibit 36)

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.

---

[3]

- 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 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 abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2 as found in SSL § 493(4)(b), which is defined as follows:

> 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 abuse and/or 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 abuse and/or 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 acts 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 neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report. Specifically, the evidence does not establish that the Subject committed neglect.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-34; 36-38) The investigation underlying the substantiated report was conducted by Justice Center Investigator

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 a number of documents and a video. (Subject Exhibits A-G) The following witnesses from the facility testified on behalf of the Subject: Direct Support Assistant Trainee and S Direct Support Assistant.

The Justice Center argued that the Subject was trained in the Q'Straint system, that the COTA stated that the tie downs were functioning properly in the vehicle, and therefore the Subject must not have secured the tie downs properly to the anchor, causing the wheelchair to tip. First of all, the Subject received the Q'Straint training in June of 2015 and did not begin driving the agency vehicle and transporting service recipients, including the Service Recipient until April of 2018. The Justice Center presented an email from the COTA stating that agency wide training of houses with wheelchairs/vans was initiated in March of 2018, however there is insufficient evidence in the record to establish that the Subject received this training. In her interview, the house manager[4] was asked whether all of the staff were trained prior to the incident, to which she replied in the affirmative, however there was no time frame provided as to when the training took place. The wheelchair competency form that the Justice Center presented, which would have accompanied the training in March of 2018 and been issued in July of 2018, is completely blank. (Hearing Testimony of Investigator and Subject; Justice Center Exhibits 26, 27, 31 and 36)

The Subject credibly testified that she asked her house manager for training when she began driving the agency vehicle in April of 2018 and that Staff #2[5] was instructed to show her how to secure the wheelchair in the vehicle. The Subject credibly testified that she was not trained in March of 2018 and was never given a refresher course of the training she received in 2015

4

5

before she transported the Service Recipient. During her interrogation, Staff #3[6] stated that she watched a video with the Subject and Staff #4 on how to secure a wheelchair in the van prior to the alleged incident, however when questioned as to whether it was a formal training with instructions, Staff #3 replied that it was not. (Hearing Testimony of Subject; Justice Center Exhibit 36)

In fact, the Subject received the formal Q'Straint training the day **after** the alleged incident. At the instruction of the house manager, the Subject, Staff #3 and Staff #4[7] went to the day habilitation program where the COTA performed the training using the same agency vehicle that the Subject drove on the date of the alleged neglect. This time, the wheelchair securement competency form was filled out, signed by the Subject and witnessed by an observer and is dated October 10, 2018. The COTA demonstrated and reviewed the Q'straint system with all the staff members, including the Subject. The Subject was able to show the COTA how she was taught by Staff #2 to secure the wheelchair and it was necessary for the COTA to train the Subject properly in how to use the Q'Straint system. The Subject admitted that she had been doing it wrong and it was necessary for the COTA to remove and reposition the refractors from front to back and demonstrate to the Subject where these refractors hooked onto the wheelchair. (Hearing Testimony of Subject, Staff #3 and Staff #4; Justice Center Exhibits 14 and 37; Subject Exhibit B)

This Administrative Law Judge has reviewed the video of the Q'Straint system and concludes that one cannot learn the Q'Straint system by simply watching a video but needs the detailed demonstration and hands-on training that the COTA provided. Not only are there multiple convoluted steps required to secure a wheelchair in a van, the video also portrays different explanations depending upon the type of wheelchair and model of Q'Straint used. Accordingly,

---

6

7

one would not have sufficient information or instruction from simply watching a video. Thus, even crediting Staff #3's statements made during her interrogation does not establish that the Subject was properly trained in the Q'Straint system prior to her securing the Service Recipient in the vehicle. (Justice Center Exhibits 36 and 37)

Additionally, despite the COTA's email stating that the tie downs were working properly, both the Subject and Staff #4 credibly testified that the COTA had to remove the refractors with a hammer and reposition them in the vehicle as they were not positioned correctly. In fact, Staff #3 took a video with her phone, which shows the COTA using a hammer to dislodge the retractor from the anchor. In addition, Staff #3 testified that the COTA removed all of the Q'straint components, including the refractors and hooks as they were in the wrong places and they needed to be cleaned. (Hearing Testimony of Subject, Staff #3 and Staff #4; Justice Center Exhibit 14; Subject Exhibit A)

Furthermore, the van that the Subject was driving did not even belong to the agency but was on loan from another facility and the Subject had never driven the van before. The house manager stated that there was no in-service training specific to the van that the Subject was driving on the date of the alleged incident, as the van was similar to another van that the facility used. Had an in-service training of the vehicle been provided, perhaps the COTA could have properly positioned all of the parts of the Q'Straint system and trained the Subject prior to the alleged incident. (Justice Center Exhibit 36)

The evidence does not establish that the Subject committed neglect when the Subject failed to properly secure the Service Recipient in the vehicle.

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will be amended or sealed.

DECISION: The request of [redacted] that the substantiated report dated December 13, 2018 (VPCR Master Case # 551088015) be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

This decision is recommended by Keely D. Parr, Administrative Hearings Unit.

DATED: December 13, 2019
Brooklyn, New York

Keely D. Parr, ALJ

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

In the Matter of the Appeal of

Pursuant to § 494 of the Social Services Law

EXHIBIT LIST
Adj. Case # 521091641

ALJ: Keely D. Parr
Date: 10/10/2019
Poughkeepsie, NY

PARTY	Exhibit	DESCRIPTION	PAGES	ACCEPTED	Witness
Agency	1	Report of Substantiated Finding	2	Yes	
Agency	2	Request for Amendment	5	Yes	
Agency	3	AAU Determination Letter	2	Yes	
Agency	4	PHC Notice with QPO	5	Yes	
Agency	5	Hearing Notice	2	Yes	
Agency	6	Investigative Summary Report	6	Yes	
Agency	7	OPWDD 147 Reporting Form	3	Yes	
Agency	8	Body Check Form	2	Yes	
Agency	9	Employee Statement – Subject	1	Yes	
Agency	10	Employee Statement –	1	Yes	
Agency	11	Employee Statement –	1	Yes	
Agency	12	Employee Statement –	1	Yes	
Agency	13	Medical Records	6	Yes	
Agency	14	E-mail re: Van Inspection	2	Yes	
Agency	15	Photographs of Van	5	Yes	
Agency	16	Occurrence Log	1	Yes	
Agency	17	Head Injury Precautions Form	1	Yes	
Agency	18	Daily Notes	2	Yes	
Agency	19	Dayshift Assignments	1	Yes	
Agency	20	Sign In/Sign Out Sheet	1	Yes	
Agency	21	Individual Plan of Protection	4	Yes	
Agency	22	Habilitation Plan	3	Yes	

Agency	23	Individualized Service Plan	14	Yes	
Agency	24	Behavior Guidelines	1	Yes	
Agency	25	Behavior Support Plan Review Report	2	Yes	
Agency	26	E-mails re: Training	5	Yes	
Agency	27	Training Sign-In Sheets	1	Yes	
Agency	28	Van Safety Presentation	80	Yes	
Agency	29	Policy – Transportation of Individuals Receiving Services	4	Yes	
Agency	30	Policy – Supporting Individuals to Safely Access Community Activities	5	Yes	
Agency	31	Wheelchair Securement Competency Test	1	Yes	
Agency	32	Photo – Wheelchair Restraints	1	Yes	
Agency	33	Policy – General Guidelines for Safe Van Operation	4	Yes	
Agency	34	HVDDSO Emergency Protocols	1	Yes	
Agency	35	Notice of Discipline	2	No	
Agency	36	Disc Containing the Following Interviews & Transcripts: • [redacted] • [redacted] (1 & 2) • [redacted] • [redacted] • [redacted] • [redacted] • Subject (1 & 2)	N/A	Yes	
Agency	37	Video of Wheelchair Tie Down Training	N/A	Yes	
Agency	38	E-mail from Investigator re: Video	3	Yes	
Subject	A	Video	N/A	Yes	
Subject	B	QStraint Training Certification 10/12/18	1	Yes	
Subject	C	Vehicle Safety Refresher and Wheelchair Securement Training 01/25/19	2	Yes	
Subject	D	Subject's Learning Training Sheets	4	Yes	
Subject	E	Van Safety and Ride Safe Information	22	Yes	
Subject	F	SR Medical Referral Form	1	Yes	
Subject	G	Logbook 07/31/19	1	Yes	

ENCLOSED IS THE DECISION FOR YOUR ADMINISTRATIVE HEARING

IF YOU DID NOT WIN YOUR HEARING, YOU MAY APPEAL TO THE COURTS PURSUANT TO THE PROVISIONS OF ARTICLE 78 OF THE CIVIL PRACTICE LAW AND RULES. IF YOU WISH TO APPEAL THIS DECISION, YOU MAY WISH TO SEEK ADVICE FROM THE LEGAL RESOURCES AVAILABLE TO YOU (E.G., YOUR ATTORNEY, COUNTY BAR ASSOCIATION, LEGAL AID, OEO GROUPS, ETC.) SUCH AN APPEAL MUST BE COMMENCED IN STATE SUPREME COURT WITHIN FOUR MONTHS AFTER THE DETERMINATION TO BE REVIEWED BECOMES FINAL AND BINDING. AN APPEAL IS **NOT** COMMENCED BY WRITING TO THIS OFFICE OR ANY OFFICE OR OFFICIAL OF THE NEW YORK STATE JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS, INCLUDING THE VULNERABLE PERSONS CENTRAL REGISTER