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 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]

[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] be amended and sealed is denied, except as to the Category. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated allegation should properly be 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: January 29, 2016
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: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Justice Center
333 East Washington Street
Syracuse, New York 13202-1405
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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New York State Justice Center for the Protection of People with Special Needs
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By: Theresa Wells, Esq.

[redacted]

[redacted]

JURISDICTION

The New York State Vulnerable Persons Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and/or 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 14 NYCRR 700.

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 report "substantiated" on [redacted], received and dated [redacted], of neglect by the Subject of a Service Recipient.

2. After investigation the Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Allegation 1

> It was alleged that between [redacted] and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to properly care for a service recipient's incision site and failed to notify his physician at the first sign of an infection.
>
> 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 [redacted], known as the [redacted], is operated by [redacted] and is certified by the New York State

[redacted]

Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject had been employed by [redacted] for six years as a Licensed Practical Nurse (LPN).

6. At the time of the alleged neglect, the Service Recipient was a person who was twenty-two years of age, with diagnoses of cerebral palsy and profound intellectual disabilities. The Service Recipient was non-ambulatory and non-verbal. The Service Recipient was also bedridden, had a rod installed into his spine and suffered from severe muscle spasms secondary to the cerebral palsy. The purpose of the rod was to stabilize the Service Recipient's spine which was prone to twisting because of the muscle spasms. (Hearing testimony of [redacted] Investigator [redacted])

7. Prior to the investigation, the Service Recipient had a baclofen pump installed into his spine. The pump delivered the medication baclofen, a muscle relaxant. On [redacted], the Service Recipient had surgery to remove his existing baclofen pump, and install a new baclofen pump. (Hearing testimony of [redacted] Investigator [redacted])

8. On [redacted], the Subject and another staff person retrieved the Service Recipient from the hospital. (Hearing testimony of [redacted] Investigator [redacted]) The discharge instructions dictated that the Service Recipient's surgeon was to be notified if the incision opened; there was increased tenderness, redness, or swelling at the wound site; or the incision site became warm or showed signs of drainage or tenderness. (Justice Center Exhibit 29)

9. At the time of discharge, the surgeon spoke with the Subject and advised that the Service Recipient's wound site should not be rubbed or scrubbed because of the Service

[redacted]

Recipient's compromised skin integrity. (Justice Center Exhibit 29) The Subject specifically asked the surgeon if it was acceptable to wash the wound incision. The surgeon responded that the Service Recipient could start showering two days post discharge, and that at that time the incision could be exposed to soapy water and thoroughly patted dried after showering. (Hearing testimony of the Subject)

10. After returning to the facility, the Subject, in consultation with the facility Registered Nurse (RN), wrote on a facility bulletin board (which was utilized to convey important information about facility service recipients), that direct care personnel were "not to wash" the wound site. (Hearing testimony of [redacted] Investigator [redacted] and Hearing testimony of the Subject) As a result, over the next several days the Service Recipient's incision site was not washed. (Hearing testimony of [redacted] Investigator [redacted]) All direct care staff at the facility had access to the written discharge instructions which were prepared by the hospital. (Hearing testimony of the Subject)

11. The Subject went on vacation on [redacted], and returned from vacation on [redacted]. On [redacted], after noting the incision area had reddened, the Subject spoke with the facility RN. (Justice Center Exhibit 13 and Hearing testimony of [redacted] Investigator [redacted]) The facility RN also examined the Service Recipient on [redacted] and advised the Subject that there was no cause for concern. (Hearing testimony of the Subject)

12. On [redacted], the Subject asked the facility RN, who was not scheduled to work on that date, to come to the facility and examine the Service Recipient. As a result, the facility RN examined the Service Recipient and determined that the Service Recipient had no fever. Because the Service Recipient was scheduled to see his surgeon for suture removal the

following day, the facility RN stated that she had no concerns. (Hearing testimony of the Subject)

13. On [redacted], the Service Recipient was seen by his surgeon for suture removal; however, inflammation at the incision site was so significant that the surgeon was unable to remove the sutures. The Service Recipient went from his surgeon's office to a hospital emergency room, where he was diagnosed with cellulitis and was prescribed an antibiotic. (Justice Center Exhibits 13, 26, 27 and Hearing testimony of [redacted] Investigator [redacted]) The Service Recipient's discharge from the hospital emergency room included instructions to obtain "prompt medical attention . . . ," should any of the following occur: spreading area of redness, increasing swelling or pain, appearance of pus or drainage and/or fever over 100.4º F. (Justice Center Exhibit 27, p. 2)

14. On [redacted], the Subject, who was not scheduled to work, came to the facility to check on the Service Recipient. The Subject and the facility Medication Administration Trained (A-MAT) staff person examined the wound and observed some swelling over the incision site, with some drainage but no redness and no tenderness. (Justice Center Exhibits 12 and 13) A quarter sized area of drainage was visible on the Service Recipient's T-shirt, but the Subject was unable to cause the wound site to drain by pushing on the wound. The Subject called the facility RN and conveyed this information. The facility RN told the Subject that because the Service Recipient had not yet received 24 hours of antibiotic treatment, more time should elapse before intervention. The Subject did not contact the Service Recipient's surgeon. (Hearing testimony of the Subject)

15. The Subject next called the Service Recipient's mother, who herself was an RN employed by [redacted]. The Subject described the issues she observed to the

[redacted]

Service Recipient's mother, who told the Subject that she was going to take the Service Recipient home for the weekend. (Hearing testimony of [redacted] Investigator [redacted] and Hearing testimony of the Subject) The Subject left the facility at 11:00 a.m. on [redacted]. (Hearing testimony of the Subject)

16. At approximately noon on [redacted], the Service Recipient's mother arrived at the facility and stated that she was taking the Service Recipient to her home for the weekend. At that time, the facility A-MAT staff person noted an increase in drainage and swelling compared to when she and the Subject had examined the wound earlier. She also noted that the wound was warm to the touch. (Justice Center Exhibit 12)

17. The Service Recipient's mother then left the facility to go to another provider agency facility to attend to her duties. At that time, she contacted the Service Recipient's father and they made a plan to take the Service Recipient to the hospital once they retrieved the Service Recipient from the facility. After returning to the facility, the Service Recipient's mother asked the facility A-MAT staff member what they were using to wash the wound site. The A-MAT staff member then informed her that the order on the board was to refrain from washing the wound, and just to "rinse it with water and pat dry." (Justice Center Exhibit 15)

18. The facility A-MAT staff member then called the facility RN, who told her that she would "… expect it to get worse before it gets better. And he just started meds. Give it till Monday…" (Justice Center Exhibit 12, p. 2) The facility A-MAT staff person told the facility RN that the Service Recipient's mother was upset that the facility staff was not "washing the area." The facility RN responded, "that is the orders … well I hope you didn't tell mom it was ok to wash." (Justice Center Exhibit 12, p. 2)

19. At some point during the afternoon of [redacted], the Service Recipient's

[redacted]

mother contacted the facility manager and conveyed her concerns. As a result, the manager dispatched the facility supervising RN to the facility. (Justice Center Exhibit 15) At approximately 5:00 p.m., the facility supervising RN examined the Service Recipient's wound site and found it to be red, swollen, and draining. The Service Recipient also had a slightly elevated temperature. The facility supervising RN then contacted the Service Recipient's surgeon and was advised by the surgeon to bring the Service Recipient to the hospital. (Justice Center Exhibits 10 and 32)

20. During the evening of [redacted], the Service Recipient was admitted to the hospital. On [redacted], the baclofen pump was surgically removed due to infection. Thereafter, the Service Recipient was admitted to the Intensive Care Unit and received oral baclofen which is not as effective at controlling muscle spasms as baclofen administered by pump. Consequently, the Service Recipient experienced more pronounced spasticity and greater spine twist. Oral baclofen, unlike the baclofen administered via the baclofen pump into the spine, has a negative impact on the heart muscle. (Hearing testimony of [redacted] Investigator [redacted])

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.

[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 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/or neglect of a person in a facility or provider agency is defined by SSL § 488(1). Under SSL § 488(1)(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, which is defined as follows:

> (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

[redacted]

> 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 by a preponderance of the evidence, 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 the act described as "Allegation 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-38) The investigation underlying the substantiated report was conducted by [redacted] Investigator [redacted], who was the only witness to testify in behalf of the Justice Center. The Subject testified in her own behalf and provided no other evidence.

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect. Specifically, the evidence establishes that the Subject unintentionally led facility direct care staff personnel to believe that the Service Recipient's wound site could not be washed,

[redacted]

despite the fact that the surgeon told the Subject that the wound could be washed with soapy water and patted dry. Consequently, facility direct care staff personnel did not wash the Service Recipient's wound site. Additionally, on the dates of [redacted], and [redacted], the Subject ignored, or failed to act on the orders of the Service Recipient's surgeon to contact him upon the presentation of specified signs and/or symptoms of infection, and instead the Subject relied on the facility RN to render a judgment on those issues.

Many of the facts are not in dispute. At the hearing, the Subject was asked why she did not contact, at the least, the facility supervising RN, when it appeared that the facility RN might not be properly addressing the signs of infection in the Service Recipient. In response to this question, the Subject testified that on [redacted], she emailed other facility personnel, including the [redacted] supervising RN (RN [redacted]), as well as all directors and managers, with an update on the Service Recipient's wound and her concerns about its condition. The Subject did claim that she emailed staff on [redacted], in the written statement she provided to [redacted] Investigator [redacted] at the time of the investigation. The Subject did not, however, provide any details about the content of that email, and did not allege that she voiced any concerns about the condition of the Service Recipient. (Justice Center Exhibit 13)

The Subject also testified that, despite what she wrote on the bulletin board of the facility regarding the washing the of Service Recipient's incision site, she provided specific instructions to the primary facility A-MAT staff person that the Service Recipient could shower with soapy water, but that the Service Recipient's wound site should not be scrubbed. However, the Subject's testimony is not corroborated by any evidence in the record. In fact, the primary

[redacted]

facility A-MAT staff person indicated, by reference to her own conversation with the facility RN on [redacted], that no facility direct care staff personnel had been washing the Service Recipient's wound site. (Justice Center Exhibit 12, p. 2)

The Subject also testified that she was counseled by her superiors against exercising any independent judgment in nursing, and that all decisions were to be vetted through the facility RN. The Subject testified that she was advised that she was not even permitted to place a band aid on a Service Recipient without first clearing it with the facility RN.

Nonetheless, [redacted] Investigator [redacted] testified that all facility personnel are required to follow medical discharge instructions and other medical orders. The Subject had a duty to contact the Service Recipient's surgeon at the first sign of infection, irrespective of the facility RN's evaluation of the situation or the Subject's chain of command. Despite this duty, the Subject failed to contact the Service Recipient's surgeon.

The Justice Center proved by a preponderance of the evidence not only that the Subject's inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. 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.

The report will remain substantiated and the next question to be decided is whether the substantiated report constitutes the category of 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 should be categorized as a Category 3

[redacted]

act. The Subject consistently conferenced signs of infection which she observed in the Service Recipient with her supervisor, the facility RN. Additionally, although the Subject unintentionally disseminated inaccurate or confusing discharge instructions on a facility bulletin board, all direct care staff had access to the relevant written discharge instructions generated by the hospital.

A substantiated Category 3 finding of abuse and/or 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 NY SSL § 496 (2). This report will be sealed after five years.

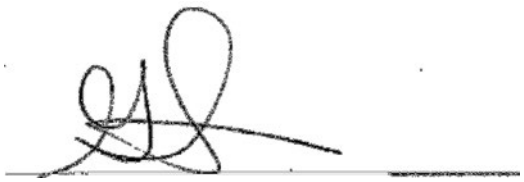
DECISION: The request of [redacted] that the substantiated report [redacted], received and dated [redacted] be amended and sealed is denied, except as to the Category. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated allegation should properly be categorized as a Category 3 act.

[redacted]

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

DATED: January 15, 2016
Schenectady, New York



Gerard D. Serlin, ALJ