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: Juliane O'Brien, 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], [redacted], dated and received [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated allegation is properly categorized as a Category 2 act.

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of this report shall be retained in part by the Vulnerable Persons Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

[redacted]

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: February 11, 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
1200 East and West Road
West Seneca, New York 14224-3604
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
Appearance Waived

New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Juliane O'Brien, Esq.

[redacted]

[redacted]

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 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 "substantiated" report dated [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 ensure that a service recipient received a treatment and dietary supplement in a timely fashion.

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

Allegation 2

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 complete Nursing Oversight duties and follow-up with proper monitoring of a service recipient's treatment.

[redacted]

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, [redacted], is a group home located at [redacted], and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of OPWDD Investigator [redacted])

5. At the time of the alleged neglect, the Subject was employed by the [redacted] as a Registered Nurse (RN) and was, prior to [redacted], assigned to work with the [redacted] at the [redacted]. (Hearing testimony of Subject) The Subject was a "custodian" as that term is defined in SSL § 488(2).

6. Sometime during [redacted], two provider agency homes, including the facility, were audited by the New York State Department of Health. It was determined that the facility staff "failed miserably" in the area of medication administration. (Hearing testimony of Subject) As part of a plan of correction, the Subject was directed and assigned to the facility to monitor the Medication Administration Record (MAR) [1] and to provide nursing care. The Subject was required to report, on a monthly basis, her findings regarding the MAR to the internal quality control team of the provider agency. (Hearing testimony of Subject)

7. At the time of the alleged neglect, the Service Recipient was a sixty-six year old male, who was verbal and had multiple diagnoses, including moderate intellectual disability,

[1] The MAR is sometimes referred to in the investigation and hearing record as the "med sheets."

[redacted]

intermittent explosive disorder, obesity, Type 2 diabetes, neuropathy, immobility (wheelchair bound), and incontinence. The Service Recipient had a history of pressure wounds which were directly related to, and complicated by, his comorbidities. (Hearing testimony of OPWDD RN [redacted]) Pressure wounds are commonly staged as follows: an area of the skin reddens in Stage 1, after which a wound penetrates the first and second layers of skin in Stages 2 and 3, respectively, until the wound reaches the muscle and bone in Stage 4. (Hearing testimony of RN [redacted] and Justice Center Exhibit 5, p. 2).

8. During [redacted], the Subject was responsible for providing nursing care and oversight coverage at the facility. (Hearing testimony of the Subject) The Subject had, prior to this time, provided nursing care for the Service Recipient's pressure wounds, and was familiar with his immobility issues, diabetes and pressure wound history. (Hearing testimony of Subject)

9. The Service Recipient attended a day program Monday through Friday and departed from the facility to the program each weekday morning by 7:30 a.m. (Justice Center Exhibit 3, p. 12 and Hearing testimony of OPWDD Investigator [redacted]) On [redacted], staff at the day program program noted two pressure wounds on the Service Recipient's buttocks. (Justice Center Exhibit 17 and Hearing testimony of OPWDD RN [redacted])

10. At some point on [redacted], the Subject examined the Service Recipient at the facility. (Justice Center Exhibit 12) The Subject created a Residential Note in which she documented her assessment of the Service Recipient's wounds, including her observation that there was "… an open area on the left …" buttock which measured "2 cm x 1 cm" in size and an open area on the right buttock which measured "1.5 cm x .5 cm" in size with a "small amount of bleeding." The Subject further noted that there were "no signs" of swelling or infection. (Justice Center Exhibit 17, p. 2). The Subject also entered an identical description of the wound

[redacted]

condition in the Initial Evaluation of Pressure Wound and Pressure Wound Monitoring Forms. (Hearing testimony of Subject and Justice Center Exhibits 5, 19, 20 and 21)

11. On [redacted], the Subject received an email from the facility dietician, [redacted] (the dietician). In this email the dietician stated that after reviewing a report, she became aware that the Service Recipient had "another open area." She then suggested the use of the supplement to assist with healing the wound and preventing skin breakdown. The dietician also solicited input from the Subject regarding the matter. (Justice Center Exhibits 22 and 23) On the same day, the Subject responded by email and wrote: "Anything will help. He actually has 2 open areas …" (Justice Center Exhibit 22)

12. On [redacted], the Service Recipient was also examined by an outside medical practitioner who characterized the Service Recipient's wounds as "2 pea sized shallow open areas on the buttocks, with no evidence of infection." (Justice Center Exhibit 6, p. 4) The medical practitioner prescribed the application of an Allevyn adhesive patch (the dressing) to be used "… to cover open areas on buttocks QD 2 wounds," (Justice Center Exhibit 6), meaning once daily. (Hearing testimony of Subject and Hearing testimony of OPWDD RN [redacted])

13. The medical practitioner did not note a specific time for administration of the dressing. [redacted] Medication Policy dictates that when the medical prescriber/practitioner does not specify a time for administration of medicine and/or treatment then staff must rely upon the "[redacted] Medication Procedure Manual: Medication Administration Times Agreement" (Times Agreement) to determine when a service recipient is to receive medication and/or treatment. The Times Agreement for the Service Recipient specified that he was to receive medicine or treatment between the hours of 6:30 a.m. and 7:30 a.m. (Justice Center Exhibit 11 and ALJ Exhibit 1)

[redacted]

14. Following the medical appointment on [redacted], a facility direct care staff person transcribed the prescription for the dressing into the Medication Administration Record (MAR) for the Service Recipient. (Justice Center Exhibit 21) A different facility direct care staff person confirmed the transcriber's entry. The process of transcribing provider prescriptions and orders into the MAR required both the facility direct care staff person acting as the transcriber and the facility direct care staff person confirming the transcriber's work to compare the prescription, the medication instruction label generated by the pharmacy, and the Times Agreement. (Hearing testimony of OPWDD RN [redacted] and OPWDD Investigator [redacted]) After reviewing all the documents and labels, the transcriber properly entered, into the Service Recipient's MAR, the physician's instruction that the dressing be administered to the Service Recipient once daily between 6:30 a.m. and 7:30 a.m. All provider agency RNs, including the Subject, were required to review the MAR, at least one time per calendar week. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibit 13, p. 2)

15. After the Service Recipient's medical appointment on [redacted], and in accordance with the Nursing Oversight Policy, the Subject reviewed the Service Recipient's medical consult report and developed a Plan of Nursing Services (PONS) for staff to follow in the care of the Service Recipient's wounds. (Hearing testimony of Subject and Justice Center Exhibit 15)

16. The Service Recipient's PONS required direct care staff to document the administration of medicine and/or medical treatment in the Service Recipient's MAR, and to create a detailed description of the wound condition in the Service Recipient's Residential Notes, after each daily dressing change. Specifically, the PONS stated in relevant part that staff were instructed to note in the Residential Notes the "… appearance of wound bed, presence of odor,

[redacted]

color, amount of drainage and surrounding tissue appearance after each daily dressing change ..." (Justice Center Exhibit 15) The PONS also stated, in bold letters, that "all staff at time of initial training must read and sign the back of this (PONS) form." Ultimately, all facility staff did sign the PONS. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibit 15)

17. On [redacted], the dietician sent an email to the facility's manager (the house manager), with a copy to the Subject, in which the dietician again recommended the use of the supplement to assist in healing the Service Recipient's wounds. Attached to the email was a "diet order prescription form" that the dietician asked the house manager to send to the Service Recipient's medical care practitioner for completion. (Justice Center Exhibit 22, pp. 2-3) Generally, the house manager is responsible for facilitating communication with the service recipients' medical practitioners. (Hearing testimony of the Subject)

18. Between [redacted] and [redacted], no facility direct care staff created Residential Notes documenting the Service Recipient's wound condition after his daily dressing change as was required by the PONS. (Hearing testimony of Subject, Hearing testimony of OPWDD Investigator [redacted], Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibits 17, 18 and 27)

19. On [redacted], the Subject visited the facility but did not sign the visitor's log. (Hearing testimony of Subject and Justice Center Exhibit 12) The Subject created a Residential Note documenting, based on information reported to her by direct care staff that the pressure wounds "appear to be getting larger." The Subject examined the Service Recipient and noted that the left buttock pressure wound had doubled in size and now measured "4 cm x 2 cm." The Subject assessed the wound as a Stage 3 with some blood colored drainage noted. (Justice Center Exhibit 17) The Subject also documented that the wound on the right buttock was larger

[redacted]

and categorized it as a Stage 3 wound measuring "2 cm x 1 cm" with a small amount of blood colored drainage. (Justice Center Exhibit 17)

20. On [redacted], the dietician sent a follow-up email to the house manager inquiring as to whether the facility had received the prescription authorizing the use of the supplement. The Subject was not copied on that email. (Justice Center Exhibit 22, p. 4)

21. On [redacted], the Service Recipient was seen again by an outside medical practitioner. The medical practitioner obtained a wound tissue sample for the purpose of culturing the wound. The culture sample appears to have been obtained from the wound on the left buttock only. (Justice Center Exhibit 9, Fifth Page) The medical practitioner noted upon examination that the pressure wounds on "both buttocks are larger" and classified the wounds as a Stage 1 "pressure ulcer on the right buttock" and a Stage 2 "pressure ulcer on the left buttock." The medical practitioner advised that facility staff should continue applying the dressing once daily, but also prescribed Duoderm Hydroactive Sterile Gel (the gel), to be applied once daily, "along with" the dressing, to the wound on the left buttock. The medical practitioner did not indicate a specific time for administration of either therapy. (Justice Center Exhibit 7, p. 2, and Hearing testimony of OPWDD RN [redacted])

22. Following the [redacted] medical appointment, a facility staff person entered a note on the Health Care Data Sheet and in the Residential Notes indicating that the medical practitioner's orders required the application of the gel to the open area of the left buttock "along with" the dressing. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibits 8, 10 and 17)

23. The process of transcription required that both the transcriber and the checker compare the prescription, the medication instruction label generated by the pharmacy, and the

[redacted]

Times Agreement. (Hearing testimony of OPWDD RN [redacted]) After reviewing all the documents and labels, the facility direct care staff person acting as the transcriber erroneously entered, into the Service Recipient's MAR, that the gel was to be administered to the Service Recipient once daily at 8:00 p.m.[2] Additionally, the staff transcriber failed to enter the instruction that the gel was to be applied "along with" the dressing to the left buttock, though this instruction was correctly noted in the Health Care Data Sheets and Residential Notes. (Justice Center Exhibits 10, 17 and 18)

24. The provider agency Nursing Oversight Policy required the RN, in this case the Subject, to review the facility MAR, at least once per calendar week. Under this policy, as many as thirteen days could elapse without any provider agency RN reviewing the MAR. (Hearing testimony of OPWDD Investigator [redacted] and Justice Center Exhibit 1) In any event, the Subject believed that her directive from the provider agency internal quality control team, to review and report on the facility MAR once monthly, superseded the provider agency policy to review the MAR once per calendar week. (Hearing testimony of the Subject) As such, the Subject conducted a review of the MAR for individual service recipients once a month, at the end of the month. (Hearing testimony of the Subject)

25. Although the Subject visited the facility on [redacted], and two times on [redacted], (Justice Center Exhibit 12), the MAR transcription error went undetected until it was discovered by RN [redacted] on [redacted]. (Hearing testimony of OPWDD RN [redacted]) As a result of this transcription error, when the Service's Recipient's dressing was changed each morning between the dates of [redacted], no gel

[2] The Times Agreement dictated that the Service Recipient's medications were to be administered between 6:30 a.m. and 7:30 a.m.

[redacted]

was applied to the wound on the left buttock and the wound was without gel for at least twelve hours each day.

26. On [redacted][3], the Subject visited the facility and became aware that facility direct care staff had not been entering, in the Residential Notes, a description of the Service Recipient's wound condition after each dressing change, as required by the PONS. She did not report this omission to her superiors as required by the Nursing Oversight Policy. (Hearing testimony of the Subject and Justice Center Exhibits 12, 13, 15 and 17)

27. On [redacted], the Subject left a voice mail message for the dietician asking her to repeat the name of the recommended supplement for the Service Recipient's wounds. (Hearing testimony of Subject and Justice Center Exhibit 22)

28. On [redacted], the dietician responded to the Subject's [redacted] voice mail message via email. The dietician reiterated that "Arginaid" was the name of the supplement that she had suggested for the Service Recipient. (Justice Center Exhibit 22, p. 5)

29. On [redacted], the recommendation for the supplement was transmitted by facsimile to the Service Recipient's medical practitioner by the house manager. (Justice Center Exhibits 3 (note 26, p. 22), 10 and 17 and Hearing testimony of OPWDD RN [redacted]) There was also a clinical meeting held the same day that was attended by the Subject, house manager, dietician and other facility direct care staff to discuss the Service Recipient's pressure wounds, as well as the supplement and a follow-up appointment with the Service Recipient's medical practitioner. (Justice Center Exhibit 23)

30. Sometime between [redacted] and [redacted], the house manager directed the facility staff to remove the dressing at night in order to allow the wounds to air out.

[3] The Subject testified at the hearing that she wrote the incorrect date of [redacted], when entering her note in the Residential Notes concerning the worsening of the Service Recipient's wound condition. She clarified in her testimony that the correct date of her visit to the facility was [redacted]. (Justice Center Exhibits 12 and 17)

[redacted]

Some facility direct care staff began to follow this directive and continued to do so until [redacted]. This directive was in clear contravention of all medical practitioner orders relative to the Service Recipient. (Hearing testimony of OPWDD RN [redacted] Justice Center Exhibits 3 and 17, p. 15)

31. The Service Recipient was next examined by an outside medical practitioner on [redacted]. (Justice Center Exhibit 9) At this evaluation, the results of the culture obtained on [redacted] revealed that the antibiotic prescribed on [redacted] was ineffective against the specific bacteria identified by the culture. Based upon the information obtained from the culture, the medical practitioner prescribed a new antibiotic, one proven to be effective against the strain of bacteria revealed by the culture. The medical practitioner described the Service Recipient's pressure wound as a Stage 2 pressure ulcer on the left buttock. The medical practitioner also referred the Service Recipient to a medical practitioner specializing in wound care. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibit 9)

32. On [redacted], the Subject visited the facility. (Justice Center Exhibit 12) Though the Subject and the Nurse Administrator who handled wound care examined the Service Recipient's wound that day, no record was made of it in the Residential Notes. (Hearing testimony of the Subject and Justice Center Exhibits 12 and 17)

33. On [redacted], the Subject examined the Service Recipient and documented in the Residential Notes that the wound on the Service Recipient's left buttock was "4 cm x 2.5 cm" in size and that drainage with an odor was present. The Subject noted that she had "drained" the wound and observed a "reddened raised area" to the left side of the wound which was "warm to touch" with the Service Recipient feeling "discomfort." (Justice Center Exhibits 10 and 17)

[redacted]

34. On [redacted], the Subject, the dietician, and RN [redacted] attended a team meeting to discuss concerns over the delay in obtaining the prescription for the supplement and the worsening of the Service Recipient's wound condition. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibits 23 (p. 2) and 27)

35. On [redacted] the Subject created a Residential Note indicating that the wound on the Service Recipient's right buttock was Stage 1, and "appears to be healing well." The Subject characterized the wound on the left buttock as Stage 2, with no drainage or odor, but with pain upon palpitation and a "pseudomonas wound infection with strep infection present." (Justice Center Exhibit 17)

36. On [redacted], the prescription for the supplement arrived at the facility via facsimile transmission from the medical practitioner. The prescription was verified by the Subject and then provided to the pharmacy. The pharmacy filled the prescription and the supplement was delivered to the facility the same day. At 8:00 p.m. that evening, the Service Recipient was administered the supplement for the first time. (Justice Center Exhibit 17)

37. On [redacted], the Subject was relieved by the provider agency of her responsibility to care for the Service Recipient. On that date, RN [redacted] assumed nursing duties of the Service Recipient. (Hearing testimony of OPWDD RN [redacted])

38. The Service Recipient was next evaluated by an outside medical practitioner on [redacted], when he was seen by a wound care specialist. RN [redacted] accompanied the Service Recipient to the medical appointment. The wound care practitioner continued the most recent antibiotic prescription, and in addition, prescribed a chemical debridement agent to dissolve the necrotic tissue in the wound on the left buttock. The left buttock wound could not be staged when viewed by the wound care practitioner because the damaged tissue prevented

[redacted]

good visualization of the wound bed. (Justice Center Exhibit 10, p. 3, and Hearing testimony of OPWDD RN [redacted])

39. As time progressed, the Service Recipient's wound condition continued to worsen. On [redacted], the Service Recipient was hospitalized with sepsis and the left buttock wound was surgically debrided. After debridement, the left buttock wound was characterized as a Stage 4 wound. The Service Recipient was discharged and returned to the facility during the last week of [redacted]. (Hearing testimony of OPWDD RN [redacted])

40. In [redacted], the Service Recipient was hospitalized again for his deteriorating pressure wound and was diagnosed with osteomyelitis, an infection of the bone. The Subject received intravenous (IV) antibiotics before being transferred to a rehabilitation facility for six weeks of additional IV antibiotics. The bone infection started in the area of the left buttock wound that had been surgically debrided on [redacted]. (Hearing testimony of OPWDD RN [redacted])

41. On [redacted], while at the rehabilitation center, the Service Recipient's condition worsened and he was admitted to the hospital with sepsis. The Service Recipient died on [redacted]. (Justice Center Exhibit 28) The Service Recipient's death was, in part, attributable to his pressure wounds and the resulting septicemia. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibit 28) At the time of the Service Recipient's death, his left buttock wound was described as a "sacral decubitus ulcer" with "osteomyelitis" that was classified as Stage 4 on the Service Recipient's "ischial tuberosity." (Justice Center Exhibit 28) Although the wound was documented in the record as being located on the Service Recipient's "ischium tuberosity," this same wound had persisted on the left buttock since [redacted]. (Hearing testimony of OPWDD RN [redacted])

[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 allegation constitutes 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 abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488. Under SSL § 488(1)(h) neglect is defined as:

> "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

[redacted]

> 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 Categories 2 and 3 which are defined in relevant parts, 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 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.
>
> (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 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 or acts of neglect cited in the substantiated report constitute 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.

[redacted]

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that the Subject committed the acts described in Allegation 1 of the substantiated report.

The Justice Center has established by a preponderance of the evidence that the Subject committed the acts described in Allegation 2 of 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- 29), all of which were accepted into evidence. Additionally, ALJ Exhibit 1, a portion of the [redacted] Medication Procedure Manual, was accepted into evidence. The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted], who, along with OPWDD RN [redacted], testified on behalf of the Justice Center at the hearing. The Subject testified on her own behalf and offered no other documentary evidence.

Allegation 1

The evidence established that the house manager was generally responsible for facilitating orders for supplements from the medical provider. The dietician did not copy the Subject on all of the emails and appeared to rely on the house manager to obtain the order for the supplement. In the initial email from the dietician to the Subject, the dietician was clearly seeking the Subject's input on whether to pursue the supplement, and was not directing or requesting that the Subject do so.

In the final analysis, based on all of the evidence, it is concluded that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged in Allegation 1 of the substantiated report. It was not established that the Subject had a duty to pursue a medical order for the supplement from the Service Recipient's

[redacted]

medical provider.

Allegation 2

The provider agency Nursing Oversight Policy states that the "… RN is responsible for developing an individualized plan for nursing services for any individual who requires nursing care or monitoring, including those who require medication administration for diagnosed medical conditions." (Justice Center Exhibit 13) The Policy also establishes that the RN is responsible for the "… assessment/supervision of DSAT/DSA/LPN staff competency regarding individual-specific nursing procedures." Furthermore, "if problems are noted the RN must notify the employee's immediate supervisor …." and any such notification must include "information regarding staff remediation." (Justice Center Exhibit 13)

In addition to the Nursing Oversight Policy, *OPWDD ADM # 2003-01*[4] establishes the duties of a provider agency RN when supervising direct care staff. It states in relevant part that:

> A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities. It is the responsibility of the employing agency to ensure that all staff is adequately trained regarding the elements of clinical nursing supervision, and the difference between clinical nursing supervision and administrative supervision.
>
> Adequate nursing supervision is the provision of guidance by an RN for the accomplishment of a nursing procedure, including:
>
> - initial training of the task or activity; and periodic inspection of the actual act of accomplishing the task or activity. The amount and type of nursing supervision required will be determined by the RN responsible for supervising the task or activity, and will depend upon:
> - the complexity of the task;

[4] The Administrative Law Judge presiding over the hearing took judicial notice of OPWDD Administrative Memorandum (ADM) #2003-01. (New York State Office for People With Developmental Disabilities, Administrative Memorandum: *Registered Nursing Supervision of Unlicensed Direct Care Staff in Residential Facilities Certified by the Office of Mental Retardation and Developmental Disabilities* [2003-01, January 2003]) This ADM can be downloaded on the OPWDD website http://www.opwdd.ny.gov/opwdd_regulations_guidance/adm_memoranda/documents/admin_memo200301 This ADM was created in 2003, and as such is written on the former Office of Mental Retardation and Developmental Disabilities' letter head.

[redacted]

- the skill, experience and training of the staff; and
- the health conditions and health status of the consumer.

In the instant case, many of the omissions, or commissions, of the direct care staff occurred while staff engaged in nursing tasks and activities that were within the scope of practice of a Licensed Practical Nurse,[5] such as completing medical documentation, caring for pressure wounds, and creating an accurate MAR. As a result, the Subject was ultimately responsible for the errors that were made by direct care staff in the provision of care to the Service Recipient.

Documentation Failures

No facility direct care staff created Residential Notes, as required by the PONS, documenting the condition of the wounds after the Service Recipient's daily dressing changes between the dates of [redacted] and [redacted]. (Hearing testimony of Subject, Hearing testimony of OPWDD Investigator [redacted], Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibits 17, 18 and 27)

On [redacted], the Subject became aware that facility direct care staff had not been completing this documentation. The Subject did not report this omission to her superiors, as required by the Nursing Oversight Policy, and did not take corrective action. (Hearing testimony of the Subject and Justice Center Exhibits 12, 13, 15 and 17)

[5] NY Education Law § 6902(2) states, in pertinent part, that: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered professional nurse … or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations."

[redacted]

MAR transcription errors

On [redacted], a facility employee erroneously transcribed into the Service Recipient's MAR that the gel was to be administered to the Service Recipient once daily at 8:00 p.m. Additionally, the transcriber failed to enter the instruction that the gel was to be applied "along with" the dressing to the left buttock, though this instruction was correctly noted in the Health Care Data Sheets and Residential Notes. (Justice Center Exhibits 10, 17 and 18)

The Subject was required by provider agency policy to review the facility MAR, at least once per week. However, the Subject erroneously believed that her directive from quality assurance, to review and report on the facility MAR at least once monthly, preempted the provider agency MAR review policy. In her interrogation with OPWDD Investigator [redacted], the Subject told the investigator that she did review the MAR, but missed the error; in her hearing testimony, however, the Subject claimed that she had not reviewed the MAR during the relevant time period.

In any event, the MAR transcription error was not discovered until [redacted]. As a result, when the Service Recipient's dressing was changed each morning beginning on [redacted] and continuing until [redacted], no gel was applied to the wound. Consequently, the wound was without the gel for at least twelve hours each day.

Ultimately, the Service Recipient's pressure wounds were determined to be a contributing factor in his death. The [redacted] medical directive, to administer the gel and the dressing together on the left buttock wound, was not followed for at least nine days. During that nine-day period, the Service Recipient's left buttock wound deteriorated. By [redacted], the left buttock wound was filled with necrotic tissue and could not be staged because visualization of the wound bed was not possible.

[redacted]

The left buttock wound continued to deteriorate and the Service Recipient experienced sepsis for the first time in [redacted]. On [redacted], the necrotic tissue in the wound on the left buttock was surgically debrided. This followed with an infection of the bone in [redacted] that was ultimately believed to have started at the site of the surgical debridement. Ultimately, even after a six week course of IV antibiotics, the Service Recipient experienced septic shock again, and died in [redacted].

The Subject argued that a significant contributing factor to the worsening of the Service Recipient's wounds was the fact that the house manager directed the facility staff to remove the dressing at night in order to allow the wounds to air out. Evidence in the record does support the conclusion that at some point in time, between [redacted], the house manager directed the facility staff to remove the wounds' dressing at night in order to allow the wounds to air out. Some facility direct care staff followed this directive and continued to do so until [redacted]. This directive was in contravention of any directive provided by a medical practitioner. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibits 3 and 17, p. 15)

The Subject argued that her neglect was not the cause of the Service Recipient's worsening wound condition; rather, it was the direct care staff's practice of removing the dressing at night, a practice of which the Subject had no knowledge, which greatly contributed to infection of the left buttock wound.

There is ample evidence in the record to conclude that the failure of the direct care staff to apply the gel and the dressing simultaneously, ultimately leaving the wound without the gel for as many as twelve hours a day for nine days, contributed to the worsening of the wound, the spread of the infection to the bone and septicemia, a contributing factor in the death of the

[redacted]

Service Recipient. The Subject was well aware that there were serious deficiencies in the area of medication administration and medical documentation at this facility, yet she failed to discover the error in the MAR, or perhaps failed to even review the MAR. The MAR was the document which all facility direct care staff relied upon to determine when medication and treatments were to be administered. Ultimately, the transcription error in the MAR was the basis for the nine days of improper treatment of the Service Recipient's pressure wounds, during which time the wound on the left buttock experienced a rapidly escalating infection.

In the final analysis, based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged in Allegation 2 of the substantiated report. 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.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented and the witnesses statements, it is determined that the substantiated report is properly categorized as a Category 2 act. A substantiated Category 2 finding of abuse or neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

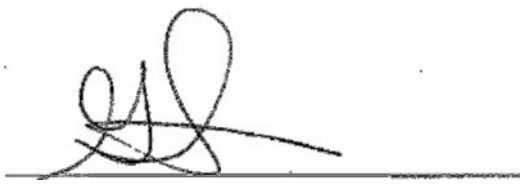
[redacted]

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

The substantiated allegation is properly categorized as a Category 2 act.

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

Dated: December 17, 2015
Syracuse, New York



Gerard D. Serlin