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]

By: Jonathan G. Johnsen, Esq.
Creighton, Johnsen & Giroux
560 Ellicott Square Building
295 Main Street
Buffalo, New York 14203

[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] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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: Schenectady, New York
March 29, 2016

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

Adjudication Case #: [redacted]

Before: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Justice Center
Administrative Hearings Unit
1200 East and West Road
West Seneca, New York 14224-3604
On: [redacted]

Parties: Vulnerable Persons' Central Register
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]

By: Jonathan G. Johnsen. Esq.
Creighton, Johnsen & Giroux
560 Ellicott Square Building
Buffalo, New York 14203

[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 Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [redacted] of neglect by the Subject of the Service Recipient.

2. After investigation of [redacted] role in the report, the Justice Center concluded that:

Allegation 1

> It was alleged that on various dates between [redacted] and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.
>
> 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

[redacted]

home located at [redacted], and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. The Subject was employed in the capacity of Direct Support Assistant (DSA). The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

5. At the time of the alleged neglect, the Service Recipient had been a resident of the facility for approximately two years. The Service Recipient was a person who used a wheelchair, but could go from a seated to a standing position for transfers. The Service Recipient was also a person with an unspecified psychiatric disorder, diabetes and significant neuropathy. The Service Recipient also experienced fecal and urinary incontinence and utilized an adult diaper. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibit 26) The Service Recipient had good verbal skills and was communicative. (Hearing testimony of OPWDD RN [redacted])

6. The Service Recipient attended a day program Monday through Friday and departed from his residence to his day program by 7:30 a.m. each morning. (Hearing testimony of OPWDD Investigator [redacted]) On [redacted][1], staff at the day program discovered and documented two pressure wounds on the Service Recipient's buttocks. (Hearing testimony of OPWDD RN [redacted])

7. On [redacted], a facility direct care staff member documented one wound on the left buttock as being 2 cm by 1 cm and one wound on the right buttock as being 1.5 cm by .5 cm, with no swelling noted. (Justice Center Exhibit 26)

[1] The record is not clear. The discovery of the pressure wound was made on either the [redacted] or the [redacted] of [redacted]. (Justice Center Exhibit 40, p.4 and Hearing testimony of OPWDD RN [redacted])

[redacted]

8. The Service Recipient had a medical appointment on [redacted], in which a medical practitioner evaluated the pressure wounds and noted the wounds to be two "pea sized" wounds 1 cm by .5 cm on the buttocks, with no evidence of infection. The medical practitioner prescribed Allevyn adhesive dressing (the dressing), 3 inch by 3 inch size to be applied once daily. (Justice Center Exhibits 12 and 13) The purpose of the dressing was not only to protect the wound from debris and foreign organisms but also to promote healing by maintaining a specified temperature range and keeping the wound moist. Once the dressing was removed and reapplied, it could take as many as four hours for the optimal temperature and moisture level of the wounds to be obtained again. (Hearing testimony of OPWDD RN [redacted])

9. The medical practitioner did not dictate a specific time of the day for administration of the dressing. [redacted] medication policy dictates that when the prescriber does not specify a time for administration of medicine, the 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. The Times Agreement for the Service Recipient specified that he should receive medicine between 6:30 a.m. and 7:30 a.m. (Justice Center Exhibit 22) All facility direct care staff members were medication administration certified (MAT Certified). (Hearing Testimony of OPWDD Investigator [redacted])

10. The Registered Nurse (RN) initially responsible for the care of the Service Recipient (Nurse-A) created a pressure wound Plan of Nursing Services (PONS) on [redacted]. The Subject signed and acknowledged the PONS. (Justice Center Exhibit 23) The PONS required that facility direct care staff document the wound condition in the Service Recipient's [redacted] residential notes after each daily dressing change. Specifically, the PONS stated,

[redacted],

in relevant part, that staff was instructed to note in the residential notes the "…appearance of wound bed, presence of odor, color, amount of drainage and surrounding tissue appearance after each daily dressing change…" (Justice Center Exhibit 23) The PONS also stated, in bold letters, "all staff at time of initial training must read and sign the back of this (PONS) form." (Justice Center Exhibit 23) The Subject signed the "PONS Q&A Signature Sheet." (Justice Center Exhibit 23)

11. Following the medical appointment of [redacted], a facility direct care staff member correctly transcribed the prescription for the dressing into the Service Recipient's Medication Administration Record (MAR). (Justice Center Exhibit 27) Another one of the facility direct care staff members verified the transcribed prescription. The process of transcription required that both the transcriber and the verifying staff compare the prescription, the medication instruction label generated by the pharmacy, and the Times Agreement. (Hearing testimony of OPWDD RN [redacted]) After review of those documents and labels, the transcribing staff correctly noted in the Service Recipient's MAR that the dressing was to be changed, once daily between 6:30 a.m. and 7:30 a.m. Nurse-A and all provider agency nurses were required to review the MAR once per week. Direct care staff members relied upon the MAR for guidance regarding medication and treatment administration. Ultimately, pursuant to provider agency practice and protocol, a service recipient's MAR dictated when, and what type of medication or treatment, that service recipient received from direct care staff. (Hearing testimony of OPWDD Investigator [redacted])

12. On [redacted], the Service Recipient's pressure wounds were evaluated by a medical practitioner. During the evaluation, the medical practitioner began to suspect infection and therefore prescribed an antibiotic. The medical practitioner also obtained a wound tissue

[redacted],

sample to culture in order to identify the bacteria and, thereafter, recommended an antibiotic that would be effective against said bacteria. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibit 14) The medical practitioner took no measurements of the pressure wounds and characterized the wounds as Stage 1[2] (right buttock) and Stage 2 (left buttock). The medical practitioner continued with the use of the dressing once daily for both wounds, 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 of the day for administration of either therapy and did not note in any written prescription that the gel was to be administered along with the dressing. (Justice Center Exhibits 14 and 15) However, one of the direct care staff[3] members who accompanied the Service Recipient to the appointment on [redacted], documented the specific directive in the [redacted] Health Care Data Sheet (Justice Center Exhibit 17) and in the residential notes, that the gel was to be administered along with the dressing. (Justice Center Exhibit 26, seventh page)

13. After the medical appointment of [redacted], a facility direct care staff member transcribed the prescription for the gel into the Service Recipient's MAR. (Justice Center Exhibit 27) The process of transcription required that both the transcribing employee and the verifying employee compare the prescription, the medication instruction label generated by the pharmacy, and the Times Agreement. (Hearing testimony of OPWDD RN [redacted] and Hearing testimony of OPWDD Investigator [redacted]) After review of those documents and labels, the transcribing employee incorrectly noted in the Service Recipient's MAR that the gel was to be administered to the Service Recipient once daily at 8:00 p.m., instead

[2] 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 OPWDD RN [redacted])

[3] The identity of the staff documenting the directive in the residential notes was never clarified in the record.

[redacted],

of 7:30 a.m. as called for in the Times Agreement. The verifying direct care staff member did not discover the error. (Hearing testimony of OPWDD RN [redacted])

14. The Subject worked the 3:00 p.m. to 11:00 p.m. shift on [redacted]. At approximately 8:00 p.m., she administered the gel to the Service Recipient's left pressure wound and documented this administration in the MAR. She removed the existing dressing when she applied the gel. (Justice Center Exhibit 27 and Hearing testimony of the Subject) She did not document the condition or her observations of the pressure wounds in the residential notes. (Justice Center 26) She did not apply a new dressing at this time, because the MAR dictated that the once daily dressing change was to occur between 6:30 a.m. and 7:30 a.m. However, the Subject did reapply the old dressing to the wound. (Hearing testimony of the Subject)

15. The Service Recipient was next evaluated by an outside medical practitioner on [redacted]. Results of the [redacted] culture were available and revealed that the antibiotic prescribed on [redacted] was ineffective against the specific bacteria identified by the culture. Based upon the information provided by the culture, the medical practitioner prescribed a different antibiotic, one known to be effective against the strain of bacteria found in the Service Recipient's pressure wounds. The medical practitioner described the Service Recipient's pressure wound on the left buttock as a Stage 2 pressure ulcer, but made no mention of the wound on the right buttock. (Justice Center Exhibit 16 and Hearing testimony of OPWDD RN [redacted])

16. The Service Recipient was next evaluated by an outside medical practitioner on [redacted], when he was seen by a wound care practitioner. OPWDD RN [redacted] accompanied the Service Recipient to the medical appointment. The medical practitioner continued the most recent antibiotic prescription as written by the medical

practitioner two days prior, and additionally prescribed a chemical debridement agent, a medication intended to dissolve necrotic tissue in the wound. The wound could not be staged when viewed by the wound care practitioner because damaged tissue prevented good visualization of the wound. (Hearing testimony of OPWDD RN)

17. From until , the Service Recipient was not seen by a health care practitioner other than RN , but phone consultations transpired between RN and the wound care practitioner on a regular basis. The Service Recipient continued to display signs of active infection. (Hearing testimony of OPWDD RN)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

[redacted],

The neglect of a person in a facility or provider agency is defined by SSL § 488(1). Neglect under SSL § 488(1)(h) 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 of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 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 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 acts of neglect alleged in the substantiated report that is the subject of the proceeding and that such acts constitute the category of neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

[redacted],

If the Justice Center proves the alleged neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the acts 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 not established by a preponderance of the evidence that the Subject committed the acts of neglect described in Allegation 1 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 1-68)

The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted], who testified at the hearing on behalf of the Justice Center. OPWDD RN [redacted] also testified at the hearing on behalf of the Justice Center.

The Subject testified on her own behalf and provided no other evidence

The hearing in this matter was conducted as a consolidated hearing, with eight Subjects. However, this decision pertains only to the Subject, [redacted]. The Subject's contact with the Service Recipient and her alleged omissions, or commissions regarding the Service Recipient, spanned approximately from [redacted], until [redacted].

While the facts are complex, in simple terms direct care staff members including the Subject were alleged to have failed to properly administer either the dressing or the gel, as well as failed to document the condition of the wound in the residential notes. The PONS required documentation of the condition of the wounds in the residential notes whenever the dressing was

changed. Direct care staff who changed the dressing in the morning should have documented the wound condition in the residential notes. (Justice Center Exhibit 23 and Hearing testimony of OPWDD RN [redacted])

Two direct care staff members incorrectly transcribed into the MAR the time for administering the gel, which ultimately caused the other facility direct care staff to incorrectly administer the gel and the dressing. Had the MAR been correctly transcribed and the dressing and the gel been administered correctly, then both treatments would have been applied simultaneously each morning at approximately 7:30 a.m.

The Subject's counsel argued that there was no proof in the record that the Subject failed to properly administer the Service Recipient's medication, and/or failed to accurately document administration of his medication, at least with regard to issues surrounding administration of the dressing. The basis for the Subject's counsel's argument was that the Subject reasonably relied upon and followed the incorrect directives contained in the MAR. Therefore, the Subject did not breach her duty to the Service Recipient. The Administrative Law Judge presiding over the hearing concludes that the Subject followed the directives for administration of medication, meaning the dressing and gel as set forth in the MAR, and therefore did not breach her duty to the Service Recipient with regard to the timing of administration or method of administration of the gel and dressing. The nearly uncontroverted evidence in the record was that direct care staff who relied upon the MAR and the medication labels to establish the method and time for administration of medications had met their obligations.

The [redacted] Medication Procedure Manual (Justice Center Exhibit 21) outlines the process that the facility direct care staff members are required to follow in the administration of medicine, and specifically in the administration of the dressing and gel. With regard to the

[redacted],

process dictated by the [redacted] Medication Procedure Manual, the proof established that every medication label should be checked against the Service Recipient's MAR before administration to the Service Recipient, and this was the expectation under which the direct care staff worked. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibit 21, p. 3)

In this case, the medication labels created by the pharmacy for the dressing and the gel were not preserved. (OPWDD Investigator [redacted]) The prescription for the gel was transmitted electronically from the medical provider to the pharmacy, and a copy was not kept at the facility. (OPWDD Investigator [redacted]) However, an electronic printout reciting the prescription, as provided by the medical provider, was generated by the pharmacy and was provided to the facility by the pharmacy. (Justice Center Exhibit 15, second page and Hearing testimony of OPWDD RN [redacted]) The electronic prescription was reviewed by Nurse-A. (Justice Center Exhibit 15, second page) However, the only administration directions regarding the gel that were contained in the electronically generated prescription were as follows: "apply to open area of left buttock wound QD one wound." (Justice Center Exhibit 15, second page) There was no directive to apply the gel along with the dressing, and the time for administration was not prescribed.

The medical practitioner's Clinical Visit Summary of [redacted], also did not specify a time of day for administration of either the gel or the dressing, and contained essentially the same directions as the prescription: "… apply to open area of left buttock wound QDone wound", with no directive that the gel was to be administered along with the dressing. (Justice Center Exhibit 14) Additionally, the PONS created on [redacted], was not updated by Nurse-A to include the gel (although it should have been), until several days after the gel prescription was added. Had the PONS been updated properly, it would have included the directive to

[redacted]

administer the dressing and the gel together. (Hearing testimony of OPWDD RN [redacted])

On [redacted], the Subject administered the gel to the Service Recipient and documented the administration of the gel in the Service Recipient's MAR. The PONS did not require that the wound condition be documented in the residential notes when the gel was applied, and only required documentation when the wound dressing was changed.

The Justice Center has not established by a preponderance of the evidence that the Subject failed to properly document the status updates for the Service Recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

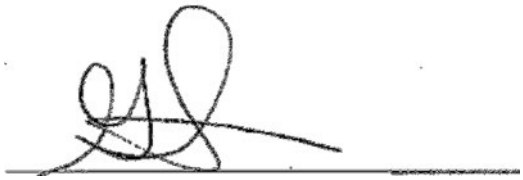
The Justice Center did not prove by a preponderance of the evidence that the Subject's inaction and/or lack of attention breached her duty to the Service Recipient, or that the likely result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, it is determined that the Justice Center has 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 and sealed.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

[redacted],

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

DATED: March 10, 2016
Syracuse, New York



Gerard D. Serlin