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: Thomas C. Parisi, Esq.

[redacted]

By: Aaron E. Kaplan, Esq.
CSEA, Inc.
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224

[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. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

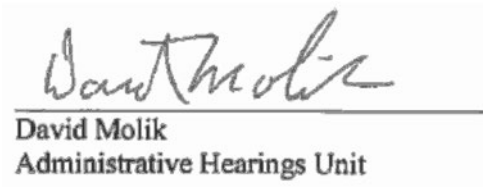
The substantiated report should be properly categorized as a Category 2 act.

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 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: March 28, 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: Jean T. Carney
Administrative Law Judge

Held at: Administrative Hearings Unit New York State Justice Center for the Protection of People with Special Needs, State Office Building
333 East Washington Street
Syracuse, New York 13202
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
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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 a Service Recipient.

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

Offense 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, your knowing, reckless, or criminally negligent failure to perform a duty caused death, and you committed neglect, when you failed to adhere to a service recipient's IPOP by not maintaining arms-length distance of her and by not checking on her at least every 10 minutes, which meant that you did not timely provide medical care when she suffered heart failure, and when you failed to both perform CPR and call 911 when you found the service recipient unresponsive.
>
> These allegations have been SUBSTANTIATED as Category 1 neglect, pursuant to Social Services Law § 493(4)(a)(ii).

3. An Administrative Review was conducted and as a result the substantiated report was retained.

4. The facility, located at [redacted] is an acute

medical house for adults who require full assistance and is operated by the Office for People With Developmental Disabilities (OPWDD), which is a facility or 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 OPWDD since [redacted] 2012 as a Licensed Practical Nurse (LPN). (Hearing testimony of Justice Center Investigator [redacted], and Justice Center Exhibit 25)

6. At the time of the alleged neglect, the Service Recipient was 82 years of age, and had been a resident of the facility for approximately 14 years. The Service Recipient was a non-ambulatory, non-verbal, elderly woman, with diagnoses of profound mental retardation and seizure disorder. (Justice Center Exhibit 29, and Hearing testimony of Investigator [redacted])

7. The Service Recipient's Individual Plan of Protective Oversight (IPOP), updated on [redacted], requires that staff check on her a minimum of every 10 minutes. According to the IPOP, the Service Recipient has a history of falling, even while seated. She also has a history of removing her tracheal tube. (Justice Center Exhibit 26)

8. On [redacted], the Subject was the designated LPN in charge, meaning that she was responsible for handling any emergency that may occur during the shift. In addition, she was assigned to feed and dispense medication to all the service recipients. (Hearing testimony of Subject)

9. As part of her normal duties, the Subject woke up the Service Recipient at about 4:00 a.m.[1], bathed and dressed her, then brought the Service Recipient out to the dining room where she was transferred from her wheelchair to a recliner near the dining room table. The

[1] The Subject consistently stated that the Service Recipient was the first to wake up in the morning, stating at various times that she awoke the Service Recipient at either 4:00 a.m. or at 4:30 a.m. She was not clear on the exact time she awoke the Service Recipient that particular morning.

Subject then dispensed medication to the Service Recipient and connected a breathing apparatus that would stream a cool mist over the Service Recipient's tracheal tube. (Justice Center Exhibits 8, 44, and Hearing testimony of Subject)

10. The Subject then turned away to address similar needs with other service recipients. By 6:00 a.m., the Subject had prepared the Service Recipient's gastric tube (G-Tube) for her breakfast. The Subject hooked it up to a bag with the Service Recipient's liquid breakfast, adjusted the drip so that the proper amount of nutrients would drip into the tube and thence into the Service Recipient's stomach. (Justice Center Exhibit 44, and Hearing testimony of Subject)

11. The Subject went back to dispensing medication and feeding the other service recipients in the house. Also at 6:00 a.m., the staff member that the Subject had worked with overnight ended her shift. Two other LPNs arrived at approximately 5:50 a.m. for their shifts starting at 6:00 a.m. (Hearing testimony of Investigator [redacted], Justice Center Exhibits 10, 11, 15, and 44)

12. About 50 minutes after starting the Service Recipient's feeding, the Subject looked over at her and noticed the Service Recipient's skin color was no longer pink, rather it was white. The Subject went to the Service Recipient, and found her unresponsive, with no pulse or respiration. She called to another LPN on staff to confirm the lack of pulse, and called time of death at 6:52. (Hearing testimony of Subject)

13. LPNs are not authorized to pronounce death. If they find an unresponsive service recipient, they are trained to call 911 and perform CPR until they are relieved by emergency medical personnel. Additionally, the Service Recipient did not have a Do Not Resuscitate Order (DNR), the absence of which requires that CPR be performed. (Justice Center Exhibits 12, 44

and Hearing testimony of Investigator [redacted])

14. The Subject called the Administrator on Duty (AOD), the Treatment Team Leader, the House Director, the Program Manager, and the Nurse on Duty (NOD). The Subject was given permission by the NOD to move the Service Recipient from the dining room to her bedroom because the Subject was concerned that the other service recipients would get upset if they saw the Service Recipient in a common area. As the Subject was moving the Service Recipient, she noticed that the Service Recipient's shirt was soiled with vomit, so she put a clean shirt on the Service Recipient and tucked her into bed.

15. As a matter of course, an autopsy was performed on the Service Recipient and cause of death was determined to have been acute ventricular arrhythmia, in lay terms, a ruptured artery. The autopsy also showed that the Service Recipient's esophagus contained "abundant regurgitated granular soft pale yellow food matter." The stomach contained "a few cc's of similar food matter." (Justice Center Exhibit 16, and Hearing testimony of 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.

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(1), to include:

> (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.

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, 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 an act, described as "Offense 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-44) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who was the only witness who testified at the hearing on 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 breached her duty to the Service Recipient when she failed to adhere to the Service Recipient's IPOP. Specifically, the evidence establishes that the Subject failed to check on the Service Recipient every 10 minutes while she was in the dining room, both before and during her breakfast. This failure delayed the discovery of the Service Recipient's death up to an hour, and foreclosed the possibility of CPR being effective. (Hearing testimony of Subject, Hearing testimony of Investigator [redacted], Justice Center Exhibits 2, 8, 10, 11, 15, 16, 26 and 44)

The Justice Center further proved by a preponderance of the evidence that the Subject breached her duty as an LPN by failing to perform CPR and failing to ensure that 911 was called when she discovered that the Service Recipient was unresponsive. (Hearing testimony of

Subject, Hearing testimony of Investigator [redacted], Justice Center Exhibits 12, 15, 16, 19, and 44)

On [redacted], the Subject was acting as a custodian as defined in Social Services Law § 488. While she may not have been assigned to the Service Recipient specifically, she was the LPN in charge that morning, and therefore was responsible for all the service recipients in the house. Furthermore, the Subject's duties included dispensing medication and feeding the Service Recipient that morning. Therefore, she had a duty of care to the Service Recipient.

The undisputed evidence introduced at the hearing shows that the Subject took on the responsibilities of caring for the Service Recipient that morning. The Subject got the Service Recipient out of bed, bathed her, dressed her, and brought her to the dining room where the Subject transferred the Service Recipient to a recliner near the dining room table. The Subject gave the Service Recipient her medication, prepared her feeding tube, and hooked up the breathing apparatus. (Hearing testimony of Subject, Hearing testimony of Investigator [redacted], Justice Center Exhibits 2, 8, 10, 11, 15 and 44) As part of these duties, the Subject should have also ensured that the Service Recipient was checked at least every 10 minutes, as mandated by the Service Recipient's IPOP. (Justice Center Exhibit 26)

The Subject gave varying statements regarding the chronology of events that morning. In her Supporting Deposition taken that morning, she said that she woke the Service Recipient at 4:00 a.m. and started feeding her at 6:30 a.m. (Justice Center Exhibit 8) Three days later, in her interrogation with Justice Center Investigator [redacted], the Subject said that she woke the Service Recipient at 4:30 a.m., and started to feed her before 6:00 a.m. Then she changed her statement to say she started feeding the Service Recipient between 6:00 a.m. and 6:30 a.m., but

closer to 6:00 a.m. and no later than 6:30 a.m. (Justice Center Exhibit 44) In her request for amendment, the Subject said that she gave the Service Recipient her medication and started feeding her at 6:30 a.m. (Justice Center Exhibit 2)

One of the LPN's who arrived for her shift at 5:50 a.m. stated in her Supporting Deposition and in her interrogation that when she arrived that morning, the Service Recipient was already being fed. (Justice Center Exhibits 11, and 44) This statement most closely corroborates the Subject's interrogation and therefore is probably most accurate.

The undisputed evidence also shows that after starting the feeding process, the Subject turned away from the Service Recipient and attended to other service recipients. In her interrogation and hearing testimony the Subject stated that she looked over at the Service Recipient from time to time, but did not recall actually going over to check on her until observing that the Service Recipient was white at 6:52 a.m. Additionally, the Subject did not recall any other staff member checking on the Service Recipient during that time. (Hearing testimony of Subject, Justice Center Exhibits 15 and 44)

Due to the Subject's failure to check on the Service Recipient, it went unnoticed when the Service Recipient aspirated her food. In addition, the Subject testified at the hearing that when feeding someone through a G-tube, certain hazards such as choking, coughing, or pulling the tube out may occur. The Subject knew about these hazards, and was aware that 10 minute checks were required as part of the Service Recipient's IPOP. Therefore, the Subject's breach was likely to result in either physical injury, or a serious or protracted impairment of the Service Recipient's physical condition.

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 issue to be determined is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. The Justice Center contends that the Subject's breach rises to the level of Category 1 conduct.[2] The Report of Substantiated Finding specifically alleges that the Subject's conduct falls under Social Services Law § 493(4)(a)(ii) which requires in relevant part "a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part…" (Justice Center Exhibit 1) There was no evidence introduced at the hearing to support the requirement of criminally negligent behavior. Rather, the Justice Center argued that the Subject's failure to call 911 and perform CPR on the Service Recipient constituted either a knowing or reckless failure to perform a duty that was likely to have resulted in physical injury to the Service Recipient that creates a substantial risk of death. However, the evidence shows that by the time the Subject discovered the Service Recipient unresponsive, she was already cold to the touch, and had most likely been dead at least 45 minutes. (Hearing testimony of Investigator [redacted]) Therefore, the Subject's failure to perform her duties of performing CPR and calling 911 could not have caused a physical injury that created a substantial risk of death, and therefore was not the likely result of her breach of duty.

[2] The parties submitted post-hearing briefs regarding the issue of Notice. The Subject contends that because the Report of Substantiated Finding specifically alleges that the Subject's "knowing, reckless, or criminally negligent failure to perform a duty caused death," then the Justice Center cannot argue at the hearing that the basis of the Category 1 finding is conduct that "results in physical injury that creates a substantial risk of death." The Subject cites insufficient notice for that argument. However, this contention is unpersuasive because the Report of Substantiated finding does specifically state that the basis of the Category 1 finding is found in Social Services Law § 493(4)(a)(ii) which when read in its entirety includes the alternative argument that the Justice Center propounded at the Hearing. Therefore, the Subject had notice of this alternative argument in the Report of Substantiated Finding.

Nonetheless, the Subject failed to perform a duty that under other circumstances could have had serious consequences. The Subject allowed her personal feelings to cloud her judgment and disregarded her training. There was considerable evidence that the Subject was distraught when she discovered that the Service Recipient had died. (Justice Center Exhibit 44, and Hearing testimony of Subject) Rather than maintaining her professional objectivity, the Subject, who considered the Service Recipient a family member, began grieving for her loss rather than following protocol.

The Justice Center also argued that the Subject's failure to check on the Service Recipient every 10 minutes, as dictated by the Service Recipient's IPOP, was a knowing or reckless failure to perform her duty that resulted in a physical injury that created a substantial risk of death. However, even the Subject's failure to perform this duty did not constitute conduct that resulted in physical injury that created a substantial risk of death. According to the Service Recipient's medical records, there was no history of heart disease. The Service Recipient had not attempted to remove her tracheal tube in two years, and she had been seizure free for 14 years. (Justice Center Exhibits 36, and 37) The Subject had no cause to suspect that the Service Recipient would suffer a cardiac event that might lead to her death. Therefore, the Subject's conduct cannot be found to be either knowing or reckless.

However, based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the failure of the Subject to check on the Service Recipient every 10 minutes, the Subject's neglect seriously endangered the health, safety or welfare of the Service Recipient. Social Services Law § 493 (4) defines Category 2 conduct as "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." (SSL § 493[4][b]) Therefore, it is determined that the substantiated report should be properly categorized as a Category 2 act.

A substantiated Category 2 finding of 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.

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

The substantiated report should be properly categorized as a Category 2 act.

This decision is recommended by Jean T. Carney, Administrative Hearings Unit.

DATED: March 17, 2016
Schenectady, New York