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]

By: John F. Black, Esq.
Hinman Straub P.C.
121 State Street
Albany, New York 12207

[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 denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

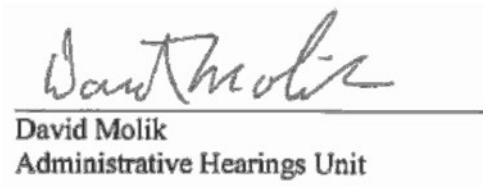
The substantiated report is properly categorized, as a Category 2 act.

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 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 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

Adjudication Case #: [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: Justice Center for the Protection of People with Special Needs
125 East Bethpage Road, Suite 104, Plainview, New York 11803
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

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[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], [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:

Allegation 1

It was alleged that on and between [redacted] and [redacted], while acting as a custodian employed by the [redacted], located at [redacted], you committed neglect when you and other custodians failed to follow the [redacted] Hospital Coverage Policy with respect to a resident of the [redacted] who was hospitalized at the [redacted] Hospital, which resulted in a protracted period of hospitalization and recovery due to the failures to provide adequate supervision and services, including, but not limited to, failures to maintain the required contact with the hospital, failures to visit the service recipient to review his status and condition, failures to document staff visits and failure to monitor whether staff was following the Hospital Coverage Policy.

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.

[redacted]

4. The facility, the [redacted], located at [redacted], is comprised of six residential group homes and a thirty-two bed [redacted] for adults with moderate to profound developmental disabilities, 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.

5. At the time of the alleged neglect, the Subject, who had been employed as the facility Treatment Team Leader (TTL) by the OPWDD for nine years, was responsible for overseeing all facility operations including the group homes and the [redacted], and for the supervision of one hundred and three employees. The Subject's regular hours of employment were [redacted]. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was a sixty-five year old resident of the facility's [redacted]. The Service Recipient was a person with a diagnosis of profound mental retardation and he suffered from numerous other severe physical and developmental issues. The Service Recipient was non-verbal, non-ambulatory, blind, deaf and completely dependent on facility staff, requiring assistance with all of his activities of daily living. (Hearing testimony of the Subject and Justice Center Exhibit 16)

7. The Service Recipient's diet consisted of liquids and pureed foods. Due to his numerous and severe disabilities, the Service Recipient was unable to feed himself and was totally "hand fed" by facility staff. (Justice Center Exhibit 17)

8. On Wednesday, [redacted], the Service Recipient was taken to and admitted by [redacted] Hospital with a diagnosis of septic shock secondary to a urinary tract infection. (Justice Center Exhibit 9)

[redacted]

9. On [redacted], the Service Recipient's assigned facility Direct Care Nurse (the Nurse) advised the Subject that the Service Recipient had been admitted to the hospital. The Subject did not ascertain whether the Nurse had visited the Service Recipient in the hospital that day and did not inquire as to when the Nurse was planning to visit the Service Recipient. (Justice Center Exhibit 24: audio interrogation of the Subject)

10. The Subject was on personal leave from her employment on Friday, [redacted]. (Hearing testimony of the Subject)

11. On Monday [redacted], the Subject was at work and she spoke with the Nurse about the Service Recipient. (Hearing testimony of the Subject)

12. The Service Recipient's facility log shows that the Nurse first visited the Service Recipient in the hospital on Tuesday, [redacted]. (Justice Center Exhibit 21)

13. The Subject worked from [redacted] until [redacted]. The Subject was on personal leave between [redacted] and [redacted]. The first day subsequent to her leave, on which the Subject returned to work was [redacted]. (Hearing testimony of the Subject)

14. From the date of his hospital admission, the Service Recipient's health deteriorated. He contracted infections and was not eating. At some point in time between [redacted] and [redacted], a temporary nasogastric feeding tube was inserted through the Service Recipient's nose to provide him with nutrition. (Hearing testimony of the Subject and Justice Center Exhibit 10)

15. At no time during the Service Recipient's hospitalization was a hospital coverage plan formulated for him and, as a result, facility staff members were never directed to attend the hospital to provide care for or to feed the Service Recipient and his care was left entirely up to

[redacted]

the hospital staff.

16. Upon the Subject's return from her personal leave on Monday, [redacted], she spoke with the Nurse about the Service Recipient and reviewed the Service Recipient's facility log, which had only three entries recorded in it. When the Subject inquired of the Nurse as to the lack of entries in the Service Recipient's facility log, the Nurse admitted to having been overwhelmed by too much paperwork and not having had sufficient time to document everything. (Hearing testimony of the Subject and Justice Center Exhibit 10)

17. In the meantime, due to the Service Recipient's continuing deterioration, a hospital doctor recommended that the Service Recipient undergo a percutaneous endoscopic gastrostomy (PEG) procedure in order to install a permanent feeding tube (the PEG tube) for adequate nutrition and hydration. Because the Service Recipient had no guardian, a Surrogate Decision Making Committee (SDMC) was required to give consent for the procedure to be performed. On [redacted], a SDMC meeting was held at [redacted] Hospital for the purpose of addressing the recommendation and consent was given for the PEG tube procedure. (Justice Center Exhibit 13)

18. The Subject brought a facility nurse practitioner, a facility speech pathologist and [redacted] to the SDMC meeting with the [redacted] Hospital staff members. At the meeting, a hospital staff member pointed out that the Service Recipient had been hospitalized for more than twenty days "...without any staff from the residence visiting him or coming to see him." The hospital staff member stated that a patient's recovery time should have only been ten days for the Service Recipient's condition upon his admission to the hospital. The hospital staff member also stated that because the facility staff was supposed to feed the Service Recipient, he had continued to lose weight and remained

[redacted]

hospitalized as a result of the lack of food, and that the facility had done no follow up while the Service Recipient was in the hospital. (Justice Center Exhibit 2: [redacted])

19. At the [redacted] SDMC meeting, the Subject and the other facility staff members were surprised that the Service Recipient needed a PEG tube. The Subject expressed her concern that the Service Recipient could not return to the facility upon his discharge from the hospital if he had a PEG tube because the facility was not equipped to provide care for service recipients with PEG tubes. The Subject then requested that prior to resorting to the necessity of the PEG tube, facility staff be given an opportunity to try to "hand feed" the Service Recipient. (Hearing testimony of the Subject)

20. On [redacted], the Subject sent a facility staff member to [redacted] Hospital for the first time, for the purpose of making an attempt to feed the Service Recipient. However, hospital nursing staff told the facility staff member that the Service Recipient should not be fed, as they were concerned that he may aspirate whatever he consumed. (Hearing testimony of the Subject)

21. On [redacted], the Service Recipient underwent the PEG tube procedure. (Justice Center Exhibit 10)

22. On [redacted], the Service Recipient was discharged to [redacted]. The Service Recipient passed away in [redacted]. (Hearing testimony of the Subject and Justice Center Exhibit 10)

23. The Service Recipient was hospitalized from [redacted] until [redacted], during which time four entries were made in the Service Recipient's facility log. The entries are the [redacted] telephone call between the Nurse and a hospital staff member, the

[redacted] and [redacted] hospital visits by the Nurse, and an [redacted] hospital visit by a facility speech pathologist. (Justice Center Exhibit 21)

24. Facility Direct Support Assistant [redacted] briefly visited the Service Recipient on [redacted], [redacted] and [redacted], while she was at [redacted] Hospital providing 1:1 supervision of a different facility service recipient. An unidentified facility staff member visited the Service Recipient on [redacted] and [redacted]. No details regarding those visits were documented. (Justice Center Exhibits 6 and 20)

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

[redacted]

> 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 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(s) committed the act or acts of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be

determined whether the act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or 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. Specifically, the evidence establishes that the Subject committed an act of neglect under SSL § 488(1)(h), in that the Subject's inaction and lack of attention to the Service Recipient's hospitalization breached her duty to the Service Recipient and that the likely, and actual, result of her breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-24) The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted][1], who testified at the hearing on behalf of the Justice Center.

The Subject testified at the hearing on her own behalf, and offered the testimony of witnesses, namely the [redacted] and a facility Direct Care Nurse. In addition, the Subject proffered one document, which was admitted into evidence. (Subject Exhibit A)

The Justice Center contended that, as a TTL, the Subject breached her duty to the Service

[1] Although OPWDD Investigator [redacted] is no longer employed by the OPWDD, she was an OPWDD Internal Investigator at the time that she conducted the investigation with respect to this matter and shall be referred to as OPWDD Investigator [redacted] herein.

[redacted]

Recipient by failing to follow the [redacted] Hospital Coverage Policy during the Service Recipient's hospitalization. The specific breaches of duty that were set out in the substantiation letter consisted of failures to provide adequate supervision and services, including but not limited to, failures to visit the Service Recipient to review his status and condition, failures to document staff visits, and failures to monitor whether staff was following Hospital Coverage Policy. It is alleged that these failures resulted in the Service Recipient's protracted period of hospitalization and recovery.

[redacted] has a written Hospital Coverage Policy (the Policy) outlining numerous facility staff responsibilities for service recipients who are admitted to the hospital. The Policy states that the Treatment Team is to assess each service recipient's needs for hospital coverage, which is documented in a service recipient's Comprehensive Functional Analysis or Plan of Protective Oversight. If a 1:1 coverage is not deemed necessary, the Treatment Team is to identify how much coverage is needed to meet the service recipient's needs in the areas of behavioral support, positioning and activities of daily living such as eating, toileting and bathing skills, while the service recipient remains hospitalized. (Justice Center Exhibit 8)

The "hospitalization coverage" area of the Service Recipient's Comprehensive Functional Analysis dated [redacted], states "type and length of coverage to be determined at time of hospitalization." (Justice Center Exhibit 15)

The Subject is responsible for all facility Treatment Teams and her name appears on the Service Recipient's Comprehensive Functional Analysis. At no time after the Service Recipient was hospitalized, did the Treatment Team take any steps to formulate a hospital coverage plan for the Service Recipient. All of the Service Recipient's needs, which were numerous, were left

[redacted]

for the hospital staff to address. Accordingly, the evidence in the record establishes that the Subject breached her duty to the Service Recipient by failing to assess the Service Recipient's needs for hospital coverage and by failing to formulate a hospital coverage plan for him, as required by the Policy.

The Policy also requires that:

> The Treatment Team Leader will ensure that unit staff/nurse visit the individual as soon as reasonably possible, but no more than 48 hours after admission to a room. The TTL or designee will provide training to alert the staff of the specific responsibilities necessary to address the individual's needs while in the hospital, and the requirements to complete supporting documentation of actions taken to address those needs. (Justice Center Exhibit 8)

The first documented hospital visit after the Service Recipient's [redacted] hospital admission occurred on [redacted], some six days later. (Justice Center Exhibits 20 and 21)

The Subject's witness, the facility Direct Care Nurse, testified that she was sure that she had visited the Service Recipient prior to [redacted] because she had observed the Service Recipient's special cup and spoon in his room when she had seen him on that date. However, there is no record of any visits other than the two that had been documented. Because the facility Direct Care Nurse's testimony on this point was uncertain and unclear and her explanation for not having documented the earlier visit was vague, her testimony is not credited. Accordingly, the evidence in the record establishes that the Subject breached her duty to the Service Recipient by failing to ensure that the Service Recipient be visited by a unit staff member or nurse within forty-eight hours after his hospital admission, as required by the Policy.

The Policy also requires that facility staff document pertinent information on a "DVP 95 note." There was no evidence of any notations on a "DVP 95 note." The only documentation made regarding the Service Recipient's hospitalization can be found in the two facility logs (Justice Center Exhibits 20 and 21), and the information contained therein is scant. The Service

[redacted]

Recipient's facility log has only four entries for the period that the Service Recipient was hospitalized. There were only a few occasions noted on the facility log (a general shift log) wherein a staff member briefly visited the Service Recipient while at the hospital on other business, and not at the direction of the Subject. Accordingly, the evidence in the record establishes that the Subject breached her duty to the Service Recipient by failing to ensure that proper documentation was made regarding him during the period of time that the Service Recipient was hospitalized, as required by the Policy.

Further, under the Policy, the TTL has several specified responsibilities which include, ensuring that service recipients are visited by facility staff within forty-eight hours of room admission (repeated in the document), communicating the service recipients' needs to hospital staff, following the service recipients' course of hospitalization, determining if other clinical services are needed, monitoring the mandatory weekly nurse's visits and reporting any significant changes to administration. (Justice Center Exhibit 8) The documentary evidence in the record and the Subject's hearing testimony establish that she did not fulfill any of these duties.

Aside from the Subject's own specific responsibilities, the Subject's duty to ensure that her staff members complied with their duties to the Service Recipient under the Policy was similarly not accomplished. For example, the Nurse had a number of responsibilities under the policy including weekly hospital visits, daily contact with the hospital and, in general, closely monitoring the Service Recipient's needs, status and condition, little of which was carried out.

Similarly, under the Policy, the facility Social Worker/Case Manager had a number of responsibilities including communicating with the hospital Social Worker as soon as possible after admission, visiting the Service Recipient within the first week of admission, providing

[redacted]

assistance in the coordination of procedures and acting as a liaison between the hospital staff and the Treatment Team. None of these tasks were completed.

The Subject's counsel argued that the Subject should not be held responsible for all of the oversights because she was on personal leave during part of the relevant time frame. The Subject was on personal leave on Friday, [redacted], and beginning after the conclusion of her shift on Friday, [redacted] and continuing until she commenced her shift on the morning of Monday, [redacted]. The OPWDD Investigator [redacted] testified that she took into account the times when the Subject was on leave in her investigation. However, the OPWDD Investigator [redacted] determined from her investigation that for the times when the Subject was actively working, her responsibilities to the Service Recipient were not met. The evidence in the record supports the investigator's conclusion.

The Subject asserted that the Service Recipient had actually been admitted to a hospital room on [redacted], and that his Nurse had visited him on [redacted]. It was argued that because of an unaccounted for discrepancy in the Service Recipient's facility log regarding the date, and because a leave date and a weekend had intervened, the Subject was not responsible for the tardiness of the first hospital visit. Even if these contentions were credited, the Subject could have and should have ensured that a staff member visited the Service Recipient on [redacted], which would have been within the mandated forty-eight hours for the first visit. In any case, the delay of the first hospital visit was only one example of the many ways in which the Subject failed to follow the Policy.

The Subject also asserted that after arriving back to work on [redacted], she would have taken measures to address the Nurse's failure to document her communications with hospital staff, had she not been directed to do nothing about it. Regardless of this argument, the

[redacted]

record reflects that prior to the start of the Subject's week long personal leave; she was at work for the entire week of [redacted] to [redacted]. During that time, the Subject took no action to rectify the failure of the Nurse to telephone the hospital daily or to properly record the substance of those conversations.

The Subject's counsel further argued that the Subject did the best that she could have done under the circumstances and that, although the record keeping was "not great," there was nothing more that she could have done that would have altered the outcome. While it may be true that even if full attention had been given and the Policy had been strictly adhered to by the Subject, the Service Recipient may still have languished in the hospital and required the PEG tube, there is no way to know this. That is why it is so critically important that the [redacted] Hospital Coverage Policy be strictly followed. The only way to ensure the best possible outcomes for service recipients is to adhere to the established high standard of care that is set out in the Policy.

Accordingly, it is found that the Subject breached her custodial duty to the Service Recipient in numerous ways.

Having determined that the Subject breached her duty to the Service Recipient, the issue then becomes whether the Subject's breach of duty resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. From the time that the Service Recipient was admitted to the hospital, his condition deteriorated. He was not eating and he contracted infections. The Subject's failure to formulate a hospital coverage plan for the Service Recipient meant that facility staff members did not attend the hospital to feed the Service Recipient and, due to lack of nutrition, he was given a nasogastric tube shortly after his admission. It was not until [redacted], more than

[redacted]

three weeks after he was admitted and despite his obvious failure to eat over the period of his hospitalization that the Subject advocated for him to be "hand fed" by facility staff. However, by then the Subject's efforts were made too late and the permanent PEG tube had already been arranged.

Had the Policy been complied with, the Service Recipient's condition and status would have been closely monitored and his unmet needs would have been addressed. The Service Recipient did not receive the care that he was entitled to under facility Policy and it is clear from the record that his physical condition deteriorated as a result.

The Justice Center has proven 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, 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 neglect under SSL § 488(1)(h), as specified in Allegation 1 of the substantiated report

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**.** 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. The Subject's neglect of the Service Recipient was prolonged and profound. It is clear from the record that the Subject's neglect seriously endangered the health, safety and welfare of the Service Recipient.

[redacted]

A substantiated Category 2 finding of abuse and/or neglect 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 2 conduct. 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], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized, as a Category 2 act.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

DATED: March 1, 2016
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge