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: Leonard Lato, Esq.
200 Motor Parkway, Suite C-17
Hauppauge, New York 11788

[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 these reports 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: April 6, 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
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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], [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 [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 [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 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.

4. The facility, [redacted], located at [redacted], is comprised of six 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 a Registered Nurse (RN) by the OPWDD for seven years, was assigned as the Service Recipient's primary Direct Care Nurse at the facility. The Subject's regular hours of employment were Monday to Friday from 8:00 a.m. until 4:30 p.m. (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 to assist him with all of his activities of daily living, including feedings and hygiene. (Hearing testimony of the Subject and Justice Center Exhibit 16)

7. On [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)

8. The Service Recipient's condition deteriorated during his hospitalization. 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. The Service Recipient required multiple intravenous antibiotics for several infections, including

pneumonia. On [redacted], the Service Recipient underwent a percutaneous endoscopic gastrostomy (PEG) procedure, in order to install a permanent feeding tube (the PEG tube) for adequate nutrition and hydration. On [redacted], the Service Recipient was discharged from the hospital to [redacted], because the facility was not equipped to provide care for service recipients with PEG tubes. The Service Recipient passed away in [redacted] 2014. (Hearing testimony of the Subject and Justice Center Exhibits 9 and 10)

9. From the time that the Service Recipient was hospitalized on [redacted] until the time that the Subject was placed on administrative leave regarding an unrelated matter on [redacted], the Subject visited the Service Recipient at [redacted] Hospital on [redacted], and on [redacted], had telephone contact with staff members of [redacted] Hospital between four and six times, and wrote three entries in the Service Recipient's facility log as records of her hospital visits and communications with staff members of [redacted] Hospital. (Justice Center Exhibits 21 and 24: audio interrogation of the Subject on [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

[redacted]

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 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.

[redacted]

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 failure to adhere to the provisions of the [redacted] Hospital Coverage Policy (the Policy) was a breach of her duty to the Service Recipient, which resulted in or was likely to result in physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional condition.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-24) The investigation underlying the

[redacted]

substantiated report was conducted by the 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 provided no other evidence.

The Justice Center's evidence established that, as the Service Recipient's assigned facility Direct Care Nurse, the Subject had a number of specific duties to the Service Recipient pursuant to the Policy (Justice Center Exhibit 8), during the Service Recipient's hospitalization, virtually all of which she failed to fulfill. Of the seven designated responsibilities that the Subject failed to perform, the three most fundamental and clear breaches of duty relative to these responsibilities were her failure to visit the Service Recipient weekly to review his status and condition, her failure to maintain daily telephone contact with the hospital, and her failure to document her visits and communication with hospital staff. Furthermore, as a member of the Service Recipient's Treatment Team, the Subject failed to formulate a hospital coverage plan for the Service Recipient. The record indicates that these failures to monitor the Service Recipient's condition closely, to communicate about his needs, and to formulate a hospital coverage plan contributed to the Service Recipient's protracted period of hospitalization and recovery.

The Policy (Justice Center Exhibit 8) requires that, as the Service Recipient's assigned Direct Care Nurse, the Subject was to conduct weekly hospital visits to the Service Recipient to review his status and condition and, as needed, to provide consultation and assistance to hospital staff regarding the Service Recipient's needs.

The only evidence of hospital visits by the Subject is contained in the Service Recipient's facility log (Justice Center Exhibit 21). The Service Recipient's facility log reflects that the

[1] Although the 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 the OPWDD Investigator [redacted] herein.

[redacted]

Subject visited the Service Recipient twice; on [redacted] and on [redacted]. The Subject testified at the hearing and told the OPWDD Investigator [redacted] that she was sure that she visited the Service Recipient three times during his hospitalization. The Subject testified that she must have 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 Subject'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.

The Service Recipient's facility log shows that, even if the Subject had been to the hospital prior to [redacted], during the thirteen day period between the two recorded visits, the Subject had not visited the Service Recipient in the hospital. Accordingly, the evidence in the record establishes that the Subject breached her duty to the Service Recipient by failing to conduct weekly hospital visits of the Service Recipient as required by the Policy.

The Policy (Justice Center Exhibit 8) also requires that, as the Service Recipient's assigned Direct Care Nurse, the Subject was to maintain daily telephone contact with the hospital nurse to obtain information regarding the Service Recipient's status. The Service Recipient's facility log reflects that, during the time that the Service Recipient was hospitalized, the Subject spoke to a hospital staff member only once; on [redacted], the day after the Service Recipient was admitted. (Justice Center Exhibit 21)

During her interrogation on [redacted], the Subject told the OPWDD Investigator [redacted] that she had telephone contact with staff members of [redacted] Hospital between four and six times. At the hearing, the Subject testified that she spoke to hospital staff once or twice a week but failed to make a record of every conversation.

[redacted]

The Subject's explanation for her failure to maintain telephone contact with the hospital was that there were a lot of other things going on, that she was satisfied with the care that the Service Recipient was receiving at the hospital, and that, even if she had spoken to the hospital every day, the Service Recipient's outcome would not have been different. Even if these contentions were all credited, they do not excuse the Subject's failure to check on the Service Recipient daily, especially in light of his total dependence on his caregivers and the fact that his condition was fragile and deteriorating. Accordingly, the evidence in the record establishes that the Subject breached her duty to the Service Recipient by failing to maintain daily telephone contact with the hospital nurse as required by the Policy.

The Policy (Justice Center Exhibit 8) also requires that the Subject document pertinent information regarding the Service Recipient's hospitalization. The only documentation made by the Subject regarding the Service Recipient's hospitalization can be found in the Service Recipient's facility log (Justice Center Exhibit 21), in which the Subject made a total of three entries (two visits and one telephone call). Interestingly, of those three entries, the Subject admitted that two of them were incorrectly dated. The Subject testified that her interactions regarding and visits to the Service Recipient, were more frequent than the Service Recipient's facility log reflects, and that it slipped her mind to record everything. She also testified that even if she had documented everything, it would not have altered the Service Recipient's outcome. Again, none of the Subject's logic excuses her failure to document visits and communications. Accordingly, the evidence in the record establishes that the Subject breached her duty to the Service Recipient by failing to adequately document information about him as required by the Policy.

Aside from her specified enumerated duties under the Policy, the Subject also failed to

[redacted]

comply with another fundamental duty that arose by virtue of the fact that the Subject was a member of the Service Recipient's Treatment Team. The Policy states that if a 1:1 coverage is not deemed necessary, the Treatment Team is to identify how much coverage is necessary to meet a hospitalized service recipient's needs in the areas of behavioral support, positioning, and activities of daily living such as eating, toileting and bathing skills, and that the Treatment Team's determination should be documented in a service recipient's Comprehensive Functional Analysis or Plan of Protective Oversight. (Justice Center Exhibit 8)

The "hospitalization coverage" area of the Service Recipient's Comprehensive Functional Analysis (Justice Center Exhibit 15) states "the type and length of coverage to be determined at time of hospitalization." The Subject and some other members of the Service Recipient's Treatment Team signed the Comprehensive Functional Analysis on [redacted].

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 his needs, which were numerous, were left for the hospital staff to address alone. One of the Service Recipient's most obvious and time consuming needs was for the provision of nutrition and hydration, which were not addressed in any way by the Treatment Team or the Subject. Accordingly, the evidence in the record establishes that, as a Treatment Team member, the Subject breached her duty to the Service Recipient by failing to formulate a hospital coverage plan for him as required by the Policy.

All of the evidence in the record clearly establishes that the Subject breached her duty to the Service Recipient in numerous ways continuously over the period of time from when the Service Recipient was admitted to the [redacted] Hospital on [redacted], until the Subject was placed on administrative leave on [redacted].

[redacted]

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. The Subject's counsel argued that, although there was "some evidence that the Subject should have gone more and called more," there was "not a shred of evidence" that the Subject's conduct caused harm or was likely to cause harm to the Service Recipient.

The Subject's counsel argued that the Service Recipient's outcome would not have been different, even if the Subject had slept at the hospital every night. Counsel also argued that, as the Service Recipient was completely uncommunicative, the question of whether there was any mental or emotional impairment, as a result of the Subject's failures to adhere to the Policy, was merely speculative. Counsel argued further that there was no evidence of physical injury or impairment, or that physical injury or impairment was a likely result of the Subject's conduct.

Under SSL § 488(6) "Physical injury" and "impairment of physical condition" means any confirmed harm, hurt or damage resulting in a significant worsening or diminution of an individual's physical condition. From the time that the Service Recipient was admitted to the hospital, his condition deteriorated. He was not eating and he contracted infections. Because there was no hospital coverage policy, no communication with the hospital and virtually no observation of the Service Recipient, the Service Recipient's condition and status were not closely monitored and his unmet needs were not addressed by any facility staff members, as they should have been. There is ample evidence in the record that there was a serious and protracted impairment of Service Recipient's condition, or at least that such impairment was likely as a result of the Subject's failure to provide the care which she was required to provide to the Service Recipient under the Policy.

[redacted]

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 the neglect 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.

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.

[redacted]

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

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

DATED: March 28, 2016
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge