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 AND ORDER 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: Laurie Cummings, Esq.

[redacted]
By: Jason P. Jaros, Esq.
8207 Main Street, Suite 13
Williamsville, New York 14221

[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 3 act.

NOW, THEREFORE, IT IS DETERMINED that 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)(c).

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: June 24, 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: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People With Special Needs
Administrative Hearings Unit
1200 East and West Road
West Seneca, New York 14224
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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By: Laura Cummings, Esq.

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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 [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to communicate a service recipient's treatment plan, as prescribed by his doctor, to the Day Habilitation Provider.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

4. The facility, located at [redacted], is an eight bed [redacted] for people with disabilities. It is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is an agency that

is subject to the jurisdiction of the Justice Center. At the time of the alleged incident, there were a total of eight service recipients who resided at the group home, two females and six males.

5. At the time of the alleged neglect, the Subject had been employed by the [redacted][1] for a total period of approximately thirty-three years. From [redacted] until [redacted], the Subject worked each weekday at the facility as a Direct Support Aide (DSA). As a part of her job duties, the Subject completed daily communication sheets that were specific to each service recipient and then signed the sheets as "[redacted]." Once the daily communication sheets were completed, they were sent from the facility to the [redacted] for the purpose of making [redacted] staff aware of the relevant facts, including medical information, related to each particular service recipient. The instructional title at the top of the fourth column of the facility's daily communication sheets, specifically states that the required information to be documented is that information relating to the Service Recipient's "Medical Issues, PRN, Meds., Apts., Injuries, Minor Log, Med. Changes." (Hearing testimonies of the Subject and OPWDD Investigator [redacted]; Justice Center Exhibit 6, page 11; and Justice Center Exhibit 10)

6. At the time of the alleged neglect, the Service Recipient was a verbal 52 year old male who was able to independently ambulate. The Service Recipient was a person with diagnoses of severe intellectual disability, obsessive compulsive disorder, explosive personality disorder and obesity. The Service Recipient had been a resident of the facility since at least 2008. During the weekdays, the Service Recipient regularly attended program at the [redacted] from approximately 9:00 a.m. until 3:00 p.m. (Hearing testimony of [redacted], OPWDD Investigator; and Justice Center Exhibits 6, 8, 15 and 21)

[1] [redacted] locally administers and oversees State operations for OPWDD.

7. At approximately 3:00 p.m. on [redacted], the Service Recipient fell while showering and hurt his left knee. The Subject was aware of the Service Recipient's fall and injury because she was working the 3:00 p.m. to 11:00 p.m. shift that day, along with a Developmental Assistant 2 (DA2) staff member (the Subject's supervisor) and a Developmental Assistant 1 (DA1) staff member. Due to a severe snow storm that day, all of the facility's service recipients remained at the facility and were not transported to their regular programs. Later in the evening of [redacted], the Service Recipient complained that his left knee was sore and, after examining the Service Recipient's knee, facility staff person A observed that the knee was slightly swollen. (Hearing testimonies of the Subject and [redacted], OPWDD Investigator; and Justice Center Exhibits 6 and 16)

8. The next day, on [redacted], the Service Recipient was transported to a medical appointment because his left knee/leg was still swollen and painful. X-rays were taken and no fracture was found. At the time of the appointment, the Service Recipient was diagnosed with a left ankle sprain/strain. Additionally, staff was instructed to continue to ice the knee for 24 hours, administer Ibuprofen as ordered for 10 days, to have the Service Recipient rest and "[k]eep knee supported with a pillow underneath when resting and comfortably elevated when possible." That same day, the DA2 entered the medical provider's prescribed treatment in the Medical Administration Record (MAR). The MAR is a record book that documents the Service Recipient's medication/medical orders and is kept in the facility's office where staff can access it. The Service Recipient remained at the facility and did not attend program on that day, [redacted] and again on [redacted]. (Hearing testimonies of the Subject and [redacted], OPWDD Investigator; and Justice Center Exhibits 6, 10, 14 and 18)

9. On [redacted] and [redacted], the Subject wrote on the daily

communication sheets that the Service Recipient was "home today" in the column specifically designated for the Service Recipient's medically related information. (Hearing testimony of the Subject; Justice Center Exhibit 10; and Justice Center Exhibit 16, page 2)

10. On Monday, [redacted], the Service Recipient attended program at the [redacted] with the other facility residents from approximately 9:00 a.m. until 3:00 p.m. The Subject made the notation "nothing to report" in the medical issues column on the daily communication sheets for that day. (Hearing testimonies of the Subject and [redacted], OPWDD Investigator; and Justice Center Exhibit 10)

11. On Tuesday, [redacted], the Service Recipient again attended program at the [redacted]. At some point that day, the Service Recipient left early to attend a follow-up medical appointment for his left knee injury and was transported by the Subject's supervisor (DA2), along with another staff member. The Subject's only notation on the daily communication sheet that morning was that the Service Recipient will be picked up "early due to apt." At the appointment, the medical provider noticed "a little swelling" on the Service Recipient's foot. The medical consultation summary listed the diagnosis for the Service Recipient's swelling and injury as a left ankle/knee sprain with a prescribed treatment plan of icing the injury for 10 minutes "t.i.d" (or three times per day) for 48 hours with elevation at "all time while sitting." The medical consultation summary also contained a recommendation that the Service Recipient engage in "weight elevated" walking daily for 30 minutes to address weight concerns.[2]

12. Thereafter, on that same day [redacted], the DA2 transcribed the Service Recipient's prescribed treatment orders from the medical provider onto the MAR which instructed

[2] Neither medical consultation on [redacted] or [redacted] had diagnosed a left foot/ankle/knee/leg fracture which required the Service Recipient to stay off of his feet. Therefore, to address the Service Recipient's obesity, his medical provider also recommended that he exercise by walking in a "weight elevated" fashion. (Justice Center Exhibit 15)

staff to follow through to "ice left ankle t.i.d. for 48 hours elevate at all time while sitting." (Hearing testimonies of the Subject and [redacted], OPWDD Investigator; and Justice Center Exhibits 10-11, 13, 15 and 18-19)

13. On [redacted], the Subject wrote in the Service Recipient's medical information column on the daily communication sheet that there was "nothing to report" and signed the sheet. Also on [redacted], while attending program at the [redacted] at about 1:00 p.m., a day habilitation staff member noticed that the Service Recipient's left foot was "very swollen" and that the "inside left ankle/heel area had purple bruising." The staff member reported this observation to the [redacted] Program Coordinator (DHPC)/Development Specialist 3 (DS3). The DHPC then contacted and spoke to the facility's DA 2 who stated that the Service Recipient's leg should be iced at home for 10 minutes 3 times per day and to "keep it elevated." Thereafter, the DA2 faxed over to the day habilitation's DHPC a copy of the [redacted] medical consultation summary, which outlined the prescribed treatment plan for Service Recipient's ankle injury. (Hearing testimonies of the Subject and [redacted], OPWDD Investigator; and Justice Center Exhibits 6, 10 and 19)

14. At about 1:00 p.m. on [redacted], the Service Recipient was seen by a medical provider for his physical therapy assessment. He presented with swelling, a large bruise on his left lower extremity and complaints of "diffuse pain around his ankle." The medical provider recommended that the Service Recipient use an ace wrap to help control the swelling. (Justice Center Exhibit 22)

15. On [redacted], after complaining of leg pain during a visit at his mother's house, the Service Recipient was taken to the hospital where he was admitted that same day. He was diagnosed with a fractured fibula in his left leg and a left ankle sprain. The Service Recipient

had surgery on [redacted] to repair the fractured fibula and a soft cast was applied to his left leg. Thereafter, on [redacted], the Service Recipient was discharged from the hospital and transferred to a rehabilitation/nursing facility. (Justice Center Exhibit 23)

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 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 neglect occurred…" [Title 14 NYCRR 700.3(f)]

The neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h), to include:

> "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.

Substantiated reports of neglect shall be categorized into categories pursuant to SSL § 493(4)(c), including Category 3, which is defined as follows:

> Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) 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 "Allegation 1" in the substantiated report. The Justice Center established that the Subject committed neglect on [redacted] when she breached her duty as a custodian by failing to communicate a Service Recipient's treatment plan as prescribed by his medical provider to the [redacted] where the Service Recipient regularly attended program. The Subject's failure to communicate a Service Recipient's treatment plan was likely to have resulted in 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 a number of documents

obtained during the investigation.[3] (Justice Center Exhibits 1-3 and 5-24) The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center. On [redacted], the Service Recipient was interviewed by Investigator [redacted]. The Service Recipient was able to verbally communicate to Investigator [redacted] that he had a fall at the facility, but he was unable to provide any additional information about the incident. (Justice Center Exhibit 6)

The Subject testified in her own behalf and provided no other evidence.

Essentially, the facts are undisputed in this case. The main items of evidence presented by the Justice Center in this case were the Service Recipient's medically related documents and the facility's daily communication sheets that were faxed over to the [redacted]. (Hearing testimonies of [redacted], OPWDD Investigator and the Subject; and Justice Center Exhibits 10-11, 13 – 15, 18 and 22) The record is clear that, as a part of the Subject's job duties on [redacted], she was assigned to properly complete the daily communication sheet. Yet, she made the entry of 'nothing to report' in the column where the Service Recipient's medical information was supposed to be documented. Prior to writing that entry, the Subject not only knew about the Service Recipient's initial knee injury occurring on [redacted], but she was also aware of the Service Recipient's follow-up appointment on [redacted] that resulted in a prescribed treatment for his knee injury that included icing the injury three times per day for 48 hours and elevating the ankle all times while sitting. Moreover, this relevant medical information was specifically transcribed in the MAR on [redacted] by the Subject's supervisor. Since the Subject had easy access to the MAR, she could have referred to it in order to properly complete the [redacted] daily communication sheets. Instead, she knowingly chose

[3] The Justice Center withdrew Exhibit 4.

to inaccurately write "nothing to report" on the communication sheet that was given to the day habilitation center. (Hearing testimony of the Subject, Justice Center Exhibits 6, 10 and 18)

All of the explanations raised by the Subject lack merit. In her hearing testimony, the Subject claimed that she wrote "nothing to report" on the [redacted] daily communication sheet based on her supervisor's instructions because the supervisor had informed her that the Service Recipient's medical information had already been provided to the day habilitation center. However, the Subject never told this to the investigator at the time of her interrogation. Contrary to the Subject's testimony, the Subject's supervisor told the investigator at the time of her interview that the Service Recipient's medical treatment plan should have been included on the daily communication sheets to the day habilitation center. In her Justice Center interrogation, the Subject agreed that she probably should have referred to the Service Recipient's [redacted] medical consultation and included the prescribed treatment plan on the communication sheet. (Hearing testimonies of the Subject and [redacted], OPWDD Investigator; and Justice Center Exhibits 6, 10, 15 and 24)

Additionally, the Subject testified that there was no clear policy concerning the completion of the daily communication sheets, that she was never properly trained to complete the daily communication sheets, and that she completed them like she had always done. However, the policy was clearly enunciated by the Subject's supervisor who stated that relevant medical information should be included on the daily communication sheet, and the Subject herself had agreed that she probably should have done this. The Subject also failed to offer any corroborating evidence to substantiate her lack of training defense. Instead, the Subject provided testimony that when she completes the communication sheets it has been her practice to only refer to the communication book and no other documents. However, this is inconsistent with what she told

the investigator. During her interrogation, the Subject told the investigator that when completing the communication sheet in this case that she probably should have looked at the medical consultation. The Subject also stated that on prior occasions, she had referred to the Health Care Data Sheets when completing the communication sheets, but did not do so in this case. (Hearing testimonies of the Subject and [redacted], OPWDD Investigator; and Justice Center Exhibits 6, 13 and 24)

The Subject further argued that because [redacted] had contacted her supervisor who then sent the Service Recipient's medical information, the center was aware of the prescribed medical orders. However, the fact that the day habilitation center obtained the medically related information through its own effort does not absolve the Subject of her duty to properly report the required information on the facility's daily communication sheet.

Moreover, it is simply logical that the Subject's actions in reporting medically related information is dictated by the purpose the communication sheet serves and the clear instructions on the face of the sheet itself. The communication sheet clearly specified at the top of the middle column what information was required to be reported to [redacted]. The record supports a conclusion that the Subject's failure to properly note on the [redacted] daily communication sheet that the Service Recipient had an injury and that his treatment plan required that the Service Recipient's ankle/knee to be iced and elevated at all times while sitting, constituted a breach of the Subject's custodial duty. The Subject's inaction was likely to have resulted in 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 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.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect as 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 3 act. A substantiated Category 3 finding of neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496 (2). This report will 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 3 act.

This decision is recommended by Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: June 17, 2016
West Seneca, New York