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: Jessica Peraza, Esq
Redan & Sugrue
135 Delaware Avenue # 410
Buffalo, New York 14202-2410

[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 granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: November 3, 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: Gerard D. Serlin
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
2165 Brighton Henrietta Town Line Rd
Rochester, New York, 14623-2755
On: [redacted]

Parties: Vulnerable Persons' Central Register
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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:

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 contact Triage after a service recipient complained of ankle pain, which was later revealed to be due to a fracture.
>
> 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 [redacted] is located at [redacted], is an [redacted] for adult individuals with developmental disabilities, and is operated by the Office for People With Developmental Disabilities (OPWDD), a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject was employed by the OPWDD. The Subject worked as a Direct Support Assistant (DSA). 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 an adult male person with developmental disabilities and a diagnosis of osteoporosis who had limited ability to ambulate on his own, and who often used a motorized scooter to ambulate. (Hearing testimony of OPWDD Investigator [redacted]) When the Service Recipient did ambulate, he did so with a limp, or an atypical gait. (Hearing testimony of the Subject and Justice Center Exhibit 16, p. 2) The Service Recipient was verbal. (Justice Center Exhibit 15, p. 7 and Hearing testimony of OPWDD Investigator [redacted]

7. On [redacted], Staff-1 and the Subject worked at the facility. At approximately 3:30 p.m. (Justice Center Exhibit 10), the Service Recipient was walking from the garage into the house when he tripped and fell. The fall was witnessed by Staff-1, but was not witnessed by the Subject. (Justice Center Exhibit 14, pp. 1-2). The Service Recipient struck his head during the fall. (Justice Center Exhibit 16, p. 2 and Exhibit 17, p. 1)

8. Staff-1 called the Subject for assistance and the Subject, who was in another part of the facility, responded to the location where the Service Recipient had fallen. (Justice Center Exhibit 14, p. 2) The Subject and Staff-1 assisted the Service Recipient to his feet and Staff-1 advised the Subject that the Service Recipient expressed that "his ankle hurts a little." (Justice Center Exhibit 12)

9. Both the Subject and Staff-1 were Medication Administration Trained (MAT Certified), (Hearing testimony of the Subject), but the Subject was assigned medication

administration duties during her shift on [redacted]. (Hearing testimony of the Subject and Justice Center Exhibit 23)

10. Staff-1 began the head injury protocol (HIP) because provider agency protocol dictated that any time a service recipient fell and struck his or her head, that the HIP was to be initiated pending consultation with the facility Registered Nurse (RN). (Justice Center Exhibit 16, p. 2) During the next several minutes, the Service Recipient walked about and traversed the hallway of the facility multiple times, with no greater difficulty than he normally experienced. (Justice Center Exhibits 12 and 16, p. 2)

11. Staff-1 did not normally work in this facility and was routinely assigned to another facility but was providing coverage on [redacted] The Subject typically worked at, and was assigned to this facility. (Justice Center Exhibit 17, pp. 3-4)

12. At 4:10 p.m., Staff-1 contacted the facility RN by telephone. Staff-1 advised the RN that the Service Recipient had fallen, that the fall was witnessed[1], that there were no visible injuries that his vital signs were normal (Justice Center Exhibit 18), and that the Service Recipient was ambulating. (Justice Center Exhibits 17, p. 2) However, Staff-1 failed to advise the RN that the Service Recipient complained of ankle pain. (Justice Center Exhibits 17, p. 2 and 18)

13. The RN instructed Staff-1 to continue the HIP, which included an on-going evaluation of the Service Recipient's vital signs every fifteen minutes for the first one-hour period after the fall, then one evaluation every three hours, followed by one evaluation every four hours and finally one evaluation of the Service Recipient after eight hours. The nurse directed that the HIP was to end no earlier than twenty-four hours after the HIP protocol began. Staff-1 "was

[1] The facility RN wrote in her statement that Staff-1 advised her that the Service Recipient's fall was witnessed and that the Service Recipient did not hit his head. (Justice Center Exhibit 18) This is assumed an error, typographical or otherwise, as the HIP was continued by the RN and it is unlikely that the RN would initiate or continue the HIP if the fall was witnessed and there was no report that the Service Recipient struck his head.

instructed to notify triage for any further concerns/injuries and to take [the Service Recipient] to the ER for any serious injury." (Justice Center Exhibit 18)

14. The Subject was not present during, and was not a party to the phone conversation between Staff-1 and the facility RN. (Hearing testimonies of OPWDD Investigator [redacted] and the Subject) Staff-1 did not relay any information obtained from the RN to the Subject beyond the fact that the HIP had been initiated. (Hearing testimony of the Subject)

15. At 7:40 p.m., the Service Recipient complained to Staff-1 that his ankle was hurting him. (Justice Center Exhibit 15) However, Staff-1 did not tell the Subject that the Service Recipient complained of ankle pain. (Hearing testimony of the Subject)

16. Standing physician orders dictated that facility staff could administer to the Service Recipient, as needed, acetaminophen (Tylenol) "for pain, discomfort, cold symptoms, or any fever equal to or greater than 101 degrees F." (Justice Center Exhibit 9, twentieth page: [redacted] Doctors Orders) The Tylenol was not secured in a locked cabinet (Hearing testimony of the Subject), and Staff-1 was aware of the fact that the Service Recipient had a standing medical order to receive Tylenol. (Justice Center Exhibit 17, p. 8) At 7:45 p.m., Staff-1 administered Tylenol to the Service Recipient. (Justice Center Exhibit 16, pp. 3-4) Staff-1 then noted in both the communications log and the Service Recipient's progress notes that he had received Tylenol at 7:45 p.m. on [redacted] (Justice Center Exhibit 17, p. 4 and Justice Center Exhibit 11) Later during the evening Staff -1 examined the Service Recipient's ankle and noted no swelling and no bruising. (Justice Center Exhibit 16, p. 4)

17. At 10:25 a.m. the following day, relief staff at the facility noted that the Service Recipient's ankle was red and swollen. (Justice Center Exhibit 8) The Service Recipient was

evaluated at the emergency room and was diagnosed with a fibula fracture. (Justice Center Exhibit 7)

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 abuse and 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 neglect of a person in a facility or provider agency is defined by SSL § 488 (1)(h) 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.

Substantiated reports of neglect shall be categorized into categories pursuant to SSL § 493(4) (c), including Category 3.

> 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 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 abuse and/or 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 not established by a preponderance of the evidence that the Subject committed the acts described in Allegation 1 of the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-26) The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted], who was then

employed as a Senior Personnel Administrator with the OPWDD [redacted] and was functioning in the capacity of an "Investigator." OPWDD Investigator [redacted] 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.

Although the events underlying the report occurred on [redacted] and continued until [redacted] there was a delay in reporting the incident, and the investigation did not begin until [redacted] when a report was made to the VPCR. (Hearing testimony of OPWDD Investigator [redacted]

Analysis of this case largely hinges upon the weight attributed to the testimony and prior statements of the Subject as contrasted by the weight attributed to statements and allegations made by Staff-1 during the course of the investigation.

The factual issue of whether the Subject or Staff-1 provided Tylenol to the Service Recipient after he complained of ankle pain is significant to the analysis of the case. During her first interrogation on [redacted], Staff-1 stated that the Service Recipient was provided Tylenol at some point during the evening after he complained of ankle pain, and Staff-1 implied during her interrogation that she herself provided the Tylenol to the Service Recipient. (Justice Center Exhibit 16, pp. 3-4)

In her second interrogation on [redacted] Staff-1 alleged that the Subject provided the Tylenol to the Service Recipient. Staff-1 stated that because the Service Recipient complained to her (Staff-1) at 7:40 p.m. that his ankle was bothering him (Justice Center Exhibit 15), at 7:45 p.m. she (Staff-1) relayed to the Subject the Service Recipient's complaint and requested that the Subject administer Tylenol to the Service Recipient. (Justice Center Exhibit 17, pp. 3, 7) Ultimately, the Subject allegedly administered 650 mg of Tylenol to the Service Recipient.

(Justice Center Exhibits 15 and 17, pp. 4, 7) Later during the evening Staff -1 examined the ankle and noted no swelling and no bruising. (Justice Center Exhibit 17, p. 3)

The Justice Center relied heavily upon the assumption that the Subject had, several hours after the fall, provided Tylenol to the Service Recipient for ankle pain to support its conclusion that the Subject breached her duty to contact triage after the Service Recipient complained of ankle pain. In support of this assumption, the Justice Center relies upon statements made by Staff-1. However, Staff-1 changed her story from the first to the second interrogation on this issue, and her new version of events is not supported by other evidence in the record. Staff-1 likely faced her own discipline and or investigation, giving her ample motive to fabricate the allegation that the Subject administered the Tylenol to the Service Recipient.

OPWDD Investigator [redacted] testified that medications in the facility, including Tylenol, were to be secured in a locked cabinet within the facility and the only the staff assigned to medication administration duties had possession of the key to the medicine cabinet. This testimony was tempered by OPWDD Investigator [redacted] display of a minimal understanding of the operation of the [redacted], and lack of basic familiarization with the provider agency's protocols and policies relevant to the issues raised in the hearing. The Justice Center argued that the Subject was assigned to medication administration duties on the evening of [redacted] and should have been the only person with access to the Tylenol.

At the hearing, the Subject testified credibly that only prescription pharmaceutical medications were secured under lock and key, and that the Tylenol was accessible to any staff. There was no other evidence in the record pertaining to this issue. Thus, the Justice Center's contention is not supported by the preponderance of the evidence in the record and consequently,

it is concluded that the Tylenol was not secured in a locked cabinet to which only the Subject had access.

While the Subject did acknowledge in some of her written statements and in her interrogation that she knew that the Service Recipient had received Tylenol (Justice Center Exhibit 13, p. 6), the Subject testified credibly at the hearing that she became aware that Staff-1 had administered the Tylenol to the Service Recipient when she reviewed some facility notes made sometime after the fall on [redacted] and before 7:00 a.m. on [redacted] which is when the Subject completed her shift. At the hearing, the Subject testified credibly that she did not administer Tylenol to the Service Recipient and that Staff-1 did not express that the Service Recipient complained of ankle pain several hours after the fall.

The uncontroverted evidence in the record establishes that Staff-1, and not the Subject, made written notations in both the communications log and the Service Recipient's progress notes documenting that the Service Recipient received Tylenol at 7:45 p.m. on [redacted]. (Justice Center Exhibit 17, p. 4 and Justice Center Exhibit 11)

The credible and convincing evidence in the record supports the conclusion that Staff-1 provided the Tylenol to the Service Recipient and that the Subject did not provide the Tylenol.

At the hearing, the Justice Center focused the proof on, and argued that, if the Subject provided Tylenol to the Service Recipient, she must have been aware of the complaint of ankle pain several hours after the fall, and therefore the Subject should have concluded that the Service Recipient's condition was worsening. However, even if the Subject was aware of the complaint of ankle pain at approximately 7:30 p.m., this was not a new complaint as the Service Recipient complained of ankle pain immediately following the fall, and the Subject was aware of the

complaint at that time. In any event, the evidence did not establish that the Subject administered the Tylenol or that she was aware of the complaint of ankle pain several hours after the fall.

During her second interrogation on [redacted], Staff-1 reported that she informed the Subject of the facility RN's instructions, which the Justice Center argues require a call to triage for a worsening condition. (Justice Center Exhibit 17, p. 5)

However, Staff-1's assertion that she advised the Subject of the RN's instructions is not credited evidence. Staff-1 was again facing her own potential discipline issues and, beyond this, she made no mention during her first interrogation of having communicated any directives from the RN to the Subject beyond those concerning continuing the HIP. (Justice Center Exhibit 16) During her second interrogation, Staff-1 alleged for the first time that she had communicated all of the instructions provided to her by the RN to the Subject. However, during the same interrogation, Staff-1 answered two questions by stating that she could not remember. At one point during the interrogation, she stated, "Yeah, it's far enough that details are starting to get fuzzy, you know." (Justice Center Exhibit 17, p. 3)

Conversely, the Subject testified credibly that Staff-1 did not provide any details of her conversation with the RN beyond that the Service Recipient was subject to the HIP.

The Subject was not present during, and was not a party to, the phone conversation between Staff-1 and the facility RN. (Hearing testimony of OPWDD Investigator [redacted] and Hearing testimony of the Subject) Staff-1 did not relay any information to the Subject beyond the fact that the HIP had been initiated. (Hearing testimony of the Subject) The Subject could not have known that the Staff-1 failed to report the ankle pain to the facility RN.

The Justice Center did not specifically allege that the Subject, who was assigned to medication administration on [redacted] should have been the staff member to contact the facility RN after the fall, and that she should not have left that task to Staff-1.

It is noteworthy that the provider agency did not have a policy identifying the staff person whose obligation it was to contact the facility RN with medical concerns, and as result of this incident, it was recommended that a policy be adopted identifying the appropriate staff to fulfill this obligation and that all staff be trained on this policy. (Hearing testimony of OPWDD Investigator [redacted]

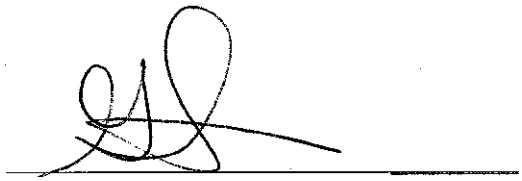
Because it is determined that the Subject had no knowledge that the Service Recipient's condition had worsened, or that the condition had not improved as the case may be, and also that the Subject had no knowledge of the RN's instructions to: " … to notify triage for any further concerns/injuries and to take [the Service Recipient] to the ER for any serious injury" (Justice Center Exhibit 18), there is not a preponderance of the evidence in the record to conclude that the Subject breached her duty to the Service Recipient. Therefore, there is no need to determine if the Service Recipient suffered actual injury because of the alleged breach, or if the alleged breach was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will be amended and sealed.

DECISION: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed is

granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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

DATED: October 18, 2016
Schenectady, New York



Gerard D. Serlin, ALJ