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: Robert T. DeCataldo, Esq.

[redacted]
By: Nicole A. Murphy, Esq.
Fine, Olin & Anderman, LLP
39 Broadway, Suite 1910
New York, NY 10006

[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 abuse and/or 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: November 2, 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: Elizabeth M. Devane
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
9 Bond Street, 3rd Floor
Brooklyn, New York 11201
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 or about [redacted] at the [redacted] located at [redacted], while acting as a custodian, you committed neglect when you breached a duty by failing to re-position a service recipient according to his protocol, during which time he sustained a pressure ulcer and/or the condition of a pressure ulcer was exacerbated, and/or creating the likelihood that he would sustain such injury or impairment.
>
> 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], located at [redacted], is operated by New York State Office for

People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of OPWDD Internal Investigator [redacted])

5. [redacted] cares for individuals with developmental disabilities. [redacted] includes Houses designated as Individualized Residential Alternatives (IRAs) and Houses designated as Intermediate Care Facilities (ICFs). ICF service recipients have more profound disabilities and require a higher level of care than service recipients in IRAs. (Hearing testimony of OPWDD Internal Investigator [redacted] Hearing testimony of the Subject)

6. At the time of the alleged neglect, the Subject was employed by [redacted] for seven years and was a Direct Support Assistant (DSA) assigned to the House [redacted] day shift, [redacted]. As a DSA, the Subject's duties included caring for service recipients and assisting with their personal needs and care plans. (Hearing testimony of OPWDD Internal Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibit 6)

7. On [redacted], the Subject was mandated to work overtime during the 3:00 p.m. to 11:30 p.m. evening shift at [redacted] House [redacted], which is an [redacted], and she was assigned to Group [redacted]. Group [redacted] consisted of three service recipients, including the Service Recipient. The Subject had worked in [redacted] "once or twice" previously. The Subject was a custodian of the Service Recipient as that term is defined in Social Services Law §488(2). (Hearing testimony of OPWDD Internal Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 7 and 9)

8. The 71 year old male Service Recipient was wheelchair dependent, unable to move his lower extremities, and his diagnoses included schizoaffective disorder, Alzheimer's disorder

and moderate mental retardation. The Service Recipient had resided at [redacted] since [redacted]. (Hearing testimony of OPWDD Internal Investigator [redacted] Justice Center Exhibits 6, 18 and 19)

9. As the Service Recipient had a recurring pressure ulcer at the sacral area of his back, a plan of care was mandated for him requiring, among other things, that the Subject be repositioned every two hours, both while in his wheelchair and when laying down, to avoid any reoccurrence of a pressure ulcer. On weekends, the Service Recipient had to be off his wheelchair and back to bed two hours after meals. A dressing was also required as a protective pad for the area. (Hearing testimony of OPWDD Internal Investigator [redacted]; Justice Center Exhibits 8, 12, 13, 14, 15, 18 and 22)

10. [redacted] required that a Positioning Sheet be completed every two hours documenting the date, time, the Service Recipient's position, position shift done, and the initials of the employee repositioning the Service Recipient. (Hearing testimony of OPWDD Internal Investigator [redacted]; Justice Center Exhibits 8 and 30)

11. For each service recipient at [redacted] there was a book which detailed their plan of care and which was available to staff. The Subject referred to the [redacted] book as the "behavior book" and OPWDD Internal Investigator [redacted] referred to the book as the "All About Me" book. (Hearing testimony of OPWDD Internal Investigator [redacted] Hearing testimony of the Subject)

12. The Service Recipient's Positioning Sheet for [redacted] through [redacted] contains no documentation showing that the Service Recipient was repositioned during the evening shift on [redacted], the overnight shift into [redacted] or the evening shift on [redacted]. (Hearing testimony of OPWDD Internal Investigator [redacted] Justice Center Exhibits 6

and 8)

13. During a shift-to-shift report on the morning of [redacted], a staff member notified Registered Nurse Nursing Administrator (RNNA) [redacted] that the Service Recipient had developed a pressure ulcer. The Medical Director and Treatment Team Leader were notified. (Hearing testimony of OPWDD Internal Investigator [redacted] Justice Center Exhibits 6 and 23)

14. During the [redacted] day shift, the Service Recipient's Primary Medical Doctor (PMD) examined and treated the Service Recipient. The PMD diagnosed a small bleeding pressure ulcer at the Service Recipient's sacral area. The PMD determined that the Service Recipient's repositioning protocol may not have been followed properly. (Hearing testimony of OPWDD Internal Investigator [redacted] Justice Center Exhibits 6 and 22)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made

as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

The 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. 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), 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 of neglect alleged in the substantiated report that is the subject of the proceeding and that such act constitutes 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 of neglect, described as "Allegation 1" in the substantiated report.

To prove neglect, the Justice Center must establish conduct by the Subject that breaches the Subject's custodian's duty to the Service Recipient and results in, or is likely to result 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. (Justice Center Exhibits 1-30, 32 and 33) The investigation underlying the substantiated report was conducted by OPWDD Internal Investigator [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center. The Subject testified in her own behalf and presented a medical letter documenting her disability leave. (Subject Exhibit A).

The credible evidence establishes that, due to the Service Recipient's history of a pressure ulcer in his sacral area, his plan of care mandated that he be repositioned every two hours and that on weekends he be off his wheelchair and back to bed two hours after meals. The Subject was a custodian for the Service Recipient during the evening shift of [redacted]. The next morning, [redacted], the Service Recipient was examined by his PMD and found to have bleeding and a pressure ulcer which occurred due to failure to follow the Service Recipient's repositioning

protocol. (Hearing testimony of OPWDD Internal Investigator [redacted]; Justice Center Exhibits 6 and 22) The Subject admitted she failed to reposition the Service Recipient at any time during the shift and the Positioning Sheet for the Service Recipient during that shift is blank. (Hearing testimony of OPWDD Internal Investigator [redacted] Hearing testimony of the Subject; Justice Center Exhibits 6 and 8)

The Subject testified that she had recently returned to work after being out for 8 months on disability and that she normally worked with service recipients who were more independent. The Subject's testimony regarding the shift details was vague. The Subject could not identify the Shift Assignment Sheet, assigning her to work with the Service Recipient, or the Service Recipient's Positioning Sheet. The Subject recognized what an Individual Checklist was and the need to complete one for all Service Recipients in every house. However, she did not recognize the Checklist for the Service Recipient during the shift in question. Although, that Checklist had her initials on it, the Subject testified that she did not write her initials on the Checklist. The Subject said she was never trained regarding positioning and did not remember being informed in any way of the need to reposition the Service Recipient. The Subject's lack of recall undermines the accuracy of her testimony, and her testimony is not fully credited.

The fact that the Subject had been out of work and that she generally worked with higher-functioning service recipients is irrelevant to her duty to this Service Recipient. The Subject had been a DSA for seven years at [redacted]. She had worked in [redacted] previously. The evidence established that all staff, including floaters, are expected to familiarize themselves with the care requirements of each service recipient for whom they are responsible. When a floater is assigned to a residence with which they are not familiar, normal facility protocol is for outgoing staff or the immediate supervisor to brief the floater upon arrival to the house. If that did not occur, it is

incumbent upon the individual staff to check the assignment they have for that shift and review each service recipient's documentation and [redacted] book. If the Subject was not informed of the Service Recipient's needs, the Subject should have made inquiries, as well as checked the Service Recipient's documentation and [redacted] book.

The Subject had an obligation to know the Service Recipient's care needs and an obligation to follow through on that care. The Subject never repositioned the Service Recipient during the shift as required. The Subject's lack of attention and failure to ascertain and follow the care required for the Service Recipient breached her duty and created the likelihood that the Service Recipient would sustain a pressure ulcer or that the condition of a pressure ulcer would be exacerbated, as did in fact occur.

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 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.

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 abuse and/or neglect.

The substantiated report is properly categorized as a Category 3 act.

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: October 17, 2016
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge