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: Donald W. O'Brien, Jr., Esq.
Woods, Oviatt & Gilman, LLP
700 Crossroads Building
2 State Street
Rochester, New York 14614

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).

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: January 13, 2017
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 Bureau
2165 Brighton Henrietta Town Line Road
Rochester, New York 14623
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
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Appearance Waived.

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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 between [redacted] and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to adequately address a service recipient's healthcare needs and failed to ensure that other custodians adhered to the instruction of the on call RN, during which time treatment of his broken femur was delayed.
>
> 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, located at [redacted], is operated by [redacted], a private not-for-profit corporation that is certified 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. The facility provides various types of assistance and services, including day care and overnight respite care to developmentally disabled persons. At the time of the incident, there were approximately eight to ten service recipients present at the facility. (Hearing testimonies of the Subject and Residential Habilitation Aid 1 [redacted], hereinafter referred to as HAB 1)

5. At the time of the alleged neglect, the Subject was employed by [redacted]. on a part-time basis and was assigned to work at the facility as a Registered Nurse (RN) in [redacted]. The Subject usually worked a flexible shift [redacted]. Occasionally, the Subject would voluntarily attend the facility during weekends to complete paperwork, although she was not paid to do so. As an RN, the Subject was responsible for providing proper medical care to the service recipients and to train facility staff for their certification in medication administration. (Hearing testimonies of the Subject and Justice Center Investigator [redacted]; Justice Center Exhibit 6) Due to her part-time employment as an "employee or volunteer of a facility or provider agency," the Subject was a custodian as that term is so defined in SSL § 488 (2)

6. At the time of the alleged neglect, the Service Recipient was a verbal fourteen year old male who resided at home with his family. He attended middle school and ambulated by using a wheelchair with staff assistance. On or about [redacted], the Service Recipient had been temporarily placed at the facility for respite care. At the time of the alleged neglect, the Service Recipient had recently been home for a holiday. (Hearing testimonies of the Subject and

HAB 1; Justice Center Exhibits 6 and 13-14)[1] The Service Recipient, who had diagnoses of cerebral palsy, hip dysplasia, spastic quadriplegia, developmental delays and other medical conditions, required twenty-four hour supervision. He was nourished by the use of a gastric feeding tube (G tube). (Justice Center Exhibits 13-14) Staff was aware of the Service Recipient's history of crying and complaining about his placement at the facility. (Hearing testimony of the Subject and Justice Center Exhibit 6)

7. At the time of the alleged neglect, HAB 1 had been working at the facility for about ten years. HAB 1's job duties involved the daily care of the service recipients, including, but not limited to, cooking, cleaning, medication administration and other tasks. (Hearing testimony of HAB 1)

8. On Friday [redacted], the Subject worked at the facility from 6:00 a.m. until 10:00 p.m., and was conducting staff medication administration certification training. HAB 1 worked the 2:00 p.m. to 10:00 p.m. shift and HAB 2 worked the 4:00 p.m. to 12:00 a.m. shift. (Hearing testimony of HAB 1; Justice Center Exhibits 6 and 19)

9. At approximately 7:00 p.m. that evening, while assisting the Service Recipient into his pajamas, HAB 1 heard cracking or popping noises emanating from the Service Recipient's left leg when it was moved. The Service Recipient began to scream and pointed to his leg after HAB 1 asked him what hurt. (Hearing testimony of HAB 1; Justice Center Exhibits 6 and 18)

10. HAB 1 then went to the Subject and advised her that the Service Recipient was crying "hysterically," that he heard "cracking" noises when he moved the Service Recipient's leg and that "something happened to his leg." At some point, HAB 1 also told HAB 2 what had

[1] There were parts of page 1 of the investigation report that contained a typographical error incorrectly noting the incident year as [redacted] and not [redacted]. The remainder the report correctly noted the proper incident date and time as "[redacted] at 7pm." (Justice Center Exhibit 6)

happened. (Hearing testimony of HAB 1; Justice Center Exhibits 6 and 18-19)

11. The Service Recipient was still crying when the Subject, HAB 1 and HAB 2 entered his bedroom. HAB 1 reiterated to the Subject that he heard "cracking" or "popping" noises when he moved the Service Recipient's leg and that something may have happened to it. The Subject examined the Service Recipient's left leg and asked him if his leg hurt. The Service Recipient replied "yes." The Subject offered the Service Recipient a dose of Tylenol, which he refused. The Subject told HAB 1 that there was nothing wrong with the Service Recipient's leg and that he probably just missed his family. HAB 1 repeatedly insisted that the Service Recipient was crying as a result of a possible leg injury, a symptom of which were the cracking sounds he had heard. None of the staff recorded the incident in a progress note. (Hearing testimonies of HAB 1 and Subject; Justice Center Exhibits 6, 8, 10, 17-19, 21 and 23)

12. From [redacted] until [redacted], the Service Recipient complained of pain in his leg and staff gave him Tylenol. At approximately 6:50 a.m. on [redacted], HAB 2 telephoned the on-call RN to report the Service Recipient's condition. The on-call RN's gave specific instructions to HAB 2 to elevate the Service Recipient's knee on a pillow, apply ice to the knee intermittently every twenty minutes until 8:00 a.m., and administer Tylenol to relieve any pain. The on-call RN further instructed HAB 2 that, in the event that the swelling in the Service Recipient's knee does not go down by 8:00 a.m., then the "first staff to walk in at 8:00 a.m." should transport the Service Recipient directly to the hospital. Accordingly, HAB 2 gave the Service Recipient a dose of Tylenol to relieve his pain and another staff applied ice to his swollen knee. HAB 2 then wrote a detailed note in the staff communication log regarding the specific instructions that he received from the on-call RN. At 7:55 a.m., the Service Recipient's leg was "still swollen and red." HAB 2 orally communicated the Service Recipient's condition

and the on call RN's instructions to HAB 3 [redacted], who was to begin her shift at 8:00 a.m., and was assigned to care for the Service Recipient. (Justice Center Exhibits 6, 9, 15, 18-19 and 22)

13. At approximately 9:20 a.m. that same morning, Sunday, [redacted], HAB 3 telephoned the Subject at her home for guidance. HAB 3 reported to the Subject that the Service Recipient's knee was swollen, that the on-call RN had been contacted, and the substance of the on-call RN instructions. The Subject advised HAB 3 to "keep the ice on and off" of the Service Recipient's knee and that, since the Subject was coming into the facility on her day off to finish paperwork, she would examine the Service Recipient's knee upon her arrival. (Hearing testimony of the Subject; Justice Center Exhibits 6, 18 and 22)

14. At approximately 11:30 a.m., the Subject arrived at the facility and examined the Service Recipient's knee. The Subject then called an ambulance to transport the Service Recipient to a hospital, which arrived at the facility at approximately 12:00 noon. Ultimately, the Service Recipient was diagnosed with a broken left femur, which required surgery. The Service Recipient was also diagnosed with osteoporosis. (Hearing testimonies of the Subject and [redacted] Investigator [redacted], Justice Center Exhibits 6, 11, 18-19, 22 and Subject's Exhibit B)

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 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), which states as follows:

> "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 2, which is defined under SSL § 493(4)(b) as follows:

> 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 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(s) of neglect cited in the substantiated report constitute 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 the acts described as "Allegation 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents and an audio CD of Subject's interrogation, obtained during the investigation. (Justice Center Exhibits 1-23) The investigation underlying the substantiated report was initially commenced by [redacted] Investigator then transferred to [redacted], the Justice Center's Investigator. Investigators [redacted] and [redacted] both testified at the hearing on behalf of the Justice Center. HAB 1 also testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and provided Subject Exhibits A, B and C.

A finding of neglect requires, in part, that a preponderance of the evidence establishes that the Subject engaged in conduct that breached her duty to the Service Recipient. In this case, as a

part-time facility RN, the Subject had a duty to provide the Service Recipient with adequate medical care. The Subject also had a duty to ensure that staff follow the on-call RN's instructions, especially when the Subject was not present at the facility.

At the hearing, the Subject denied the allegation in the substantiated report. With respect to the adequate medical care issue, the Subject testified that on Friday night, [redacted], HAB 1 initially reported to her only that the Service Recipient was crying hysterically and asked her to come to his room. The Subject testified that she complied, examined the Service Recipient's leg and it appeared normal. She testified that the Service Recipient told her his leg did not hurt so she did not offer him a dose of Tylenol pain reliever. The Subject further testified that the Service Recipient had recently returned from a family visit, that he was a "little boy" who "misses home" and was "having a tantrum." Following her physical examination of the Service Recipient, the Subject also testified that she attempted to talk to him and physically embraced him in order to calm him. The Subject then concluded that the Service Recipient's problem was "emotional" and "nothing physical." (Hearing testimony of the Subject and Justice Center Exhibits 6, 17 and 23)

However, the Subject's hearing testimony was inconsistent with her [redacted] interrogation. At the time of her interrogation, the Subject told Investigator [redacted] that on Friday night of [redacted], she did not recall whether HAB 1 told her that he heard cracking sounds in the Service Recipient's leg and that something happened to his leg. Additionally, the Subject told the investigator that when she talked to HAB 3 on [redacted], that following Sunday morning, she should have advised staff to take the Service Recipient to the hospital in accordance with the on-call RN's instructions. Moreover, during the Subject's interrogation when she was asked why her version of whether HAB 1 told her about the Service Recipient's leg cracking noises differed from HAB 1's and HAB 2's version, the Subject was unable to explain why. (Hearing

testimony of the Subject; Justice Center Exhibits 6, 17 and 23)

HAB 1's hearing testimony substantially differed from the Subject's. HAB 1 testified adamantly that when he initially reported the incident to the Subject on the evening of Friday [redacted] he specifically told her that, while he was dressing the Service Recipient, he heard cracking noises emanating from the Service Recipient's leg, that he was concerned that something happened to it and that the Service Recipient was crying as a result. HAB 1 testified that he persistently told the Subject that the Service Recipient was crying because of the cracking leg noises and not because he missed his home. HAB 1's hearing testimony was consistent with his [redacted] written statement and also confirmed that he heard the Service Recipient tell the Subject that his leg hurt. (Hearing testimony of HAB 1, Justice Center Exhibits 6, 18-19)

At the time of the initial incident, HAB 2 was also present in the Service Recipient's room with the Subject and HAB 1. In her [redacted] written statement, HAB 2 explained that she heard her co-worker HAB 1 say to the Subject that the Service Recipient's "knee popped" and that the Subject should "check it." HAB 2 further stated in her written statement that the Subject's response to HAB 1 was that the Service Recipient was "a strong guy," that it "doesn't look like anything is wrong with his knee" and that "he probably just misses his family." HAB 2 also stated that she heard the Subject say "maybe the leg pain was because he wasn't moving as much as he should" and that she heard the Service Recipient refuse the Tylenol offered to him by the Subject. HAB 2 also stated that the Service Recipient was crying and told her that his "knee hurt." (Justice Center Exhibits 6, 8, 16 and 19)

The Service Recipient was also interviewed by Investigator [redacted] on [redacted]. Since the Service Recipient was not physically able to sign his written statement, his Grandmother, who was present at the interview, signed it on his behalf. In his written statement, the Service

Recipient recalled that he first felt the pain in his leg on Friday night while HAB 1 was dressing him into his pajamas and that the pain was "a big owie." The Service Recipient further stated that the Subject examined him and offered him medication. (Hearing testimony of Investigator [redacted] and Justice Center Exhibit 21)

HAB 1's testimony regarding the incident is a highly credible, chilling and detailed eyewitness account of what happened. HAB 1's version of the incident was consistent with his [redacted] written statement. HAB 1's account and written statement were corroborated by HAB 2's [redacted] written statement, the [redacted] Event Form completed by HAB 2 close in time to the incident and the [redacted] written statement of the Service Recipient. Therefore, it is found that HAB 1's testimony is credited evidence. That part of the Subject's testimony that is inconsistent with HAB 1's testimony is not credited evidence, especially in light of the fact that the Service Recipient was ultimately diagnosed with a broken femur. (Hearing testimonies of HAB 1, Investigator [redacted] and Investigator [redacted]; Justice Center Exhibits 6, 8, 11, 18-19, 21 and Subject's Exhibit B)

Failure to Adequately Address Service Recipient's Healthcare Needs

The Justice Center has established by a preponderance of the evidence that the Subject committed neglect in that she breached her custodian's duty to the Service Recipient to obtain adequate medical treatment for his broken femur. The Subject's actions or inactions resulted, or was likely to have resulted in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

The credible evidence in the record establishes that on the evening of Friday [redacted], the Subject initially breached her duty to obtain adequate medical care for the Service Recipient. HAB 1 had reported to the Subject that the Service Recipient's crying was associated

with the cracking noises emanating from his leg. As the facility RN, the Subject had a duty to act by overseeing the Service Recipient's immediate transfer to an appropriate medical facility to have an x-ray or other diagnostic testing performed. The failure of the Subject to take proper action to obtain a diagnosis caused the Service Recipient's broken femur to remain undiagnosed and untreated for almost two days. During the period the injury remained undiagnosed, the Service Recipient intermittently suffered pain which was treated by staff with Tylenol.

The Subject raised various claims at the hearing that were all unpersuasive. Additionally, the Subject argued that at the time of the alleged incident she had no reason to suspect that the Service Recipient's had broken bones because his osteoporosis condition was undiagnosed. However, under these circumstances, that argument lacks merit and does not diminish the Subject's responsibility to obtain adequate medical care for the Service Recipient. (Hearing testimony of the Subject and Justice Center Exhibit 23)

Failure to Ensure Staff Compliance with On-Call RN's Instructions

The Justice Center has proven by a preponderance of the evidence that the Subject committed the alleged neglect. The Subject's actions or inactions resulted, or were likely to have resulted in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

The credible evidence in the record establishes that the on-call RN's early Sunday morning instructions on [redacted] required staff beginning their shift at 8:00 a.m. to transport the Service Recipient to the hospital if his knee remained swollen. At 8:00 a.m., the Service Recipient's knee was still swollen. The Subject received a 10:00 a.m. telephone call from HAB 3 who relayed to the Subject the on-call RN's instructions to staff. Nevertheless, at that time, the Subject failed to enforce the on-call nurse's instructions to transport the Service Recipient to the

hospital. Instead the Subject told staff to wait until she came into the facility to examine him. Consequently, the proper medical diagnosis and treatment of the Service Recipient's broken femur was further delayed due to the Subject's failure to direct staff to comply with the on-call RN's instructions. (Hearing testimonies of the Subject and HAB 1; Justice Center Exhibits 6, 17, 19, 22 and 23)

In her hearing testimony, the Subject claimed that, during her Sunday [redacted] 10:00 a.m. telephone call, HAB 3 never told her exactly when the call was placed to the on-call RN, implying that she had no reference point from which she could determine when staff should have taken the Service Recipient to the hospital to be examined. However, this argument is unpersuasive because HAB 3 called the Subject at home after the on-call RN's 8:00 a.m. deadline to transport the Service Recipient to the hospital had passed. Moreover, the Subject testified HAB 3 told her the on-call RN's specific instructions. With that knowledge, the Subject should have directed staff to immediately have the Service Recipient transported to the hospital.

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 2 act. Although the Subject argued that the Category 2 level is inappropriate, it is found that under these circumstances, the Category 2 level is applicable in this case. The Subject's conduct seriously endangered the health, safety and welfare of the Service Recipient.

A substantiated Category 2 finding of neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. 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 Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: January 5, 2017
Rochester, New York

Mary Jo Lattimore-Young,
Administrative Law Judge