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 DeCataldo, Esq.

[redacted]
By: Emily G. Hannigan, Esq.
Lippes Mathias Wexler Friedman, LLP
54 State Street, Suite 1001
Albany, New York 12207

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 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: January 25, 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: John T. Nasci
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
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
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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 take appropriate action to ensure that a service recipient received his prescribed medication.
>
> 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 a group home for adults with developmental disabilities, and is operated by the 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.

5. At the time of the alleged neglect, the Subject had been employed by the OPWDD as a Registered Nurse (RN) for six years, the last three of which as an RN for the [redacted] and the [redacted]. The Subject's duties as an RN included assessing service recipients, making medical appointments for service recipients, taking service recipients to medical appointments, instructing staff and families of service recipients concerning medical issues, writing reports and acting as a liaison between the service recipients' physicians, families and staff. The Subject's duties did not include administering medication to service recipients. (Hearing testimony of the Subject)

6. At the time of the alleged neglect, the Service Recipient was a fifty-six year old male resident of the [redacted] with diagnoses of profound mental retardation, autism and severe allergies. The Service Recipient also had a history of seizures, however, he had not had a seizure since 1987. (Justice Center Exhibits 10 and 17, Justice Center Exhibit 23: audio recording of Justice Center interrogation of the Subject and Hearing testimony of the Subject)

7. The Service Recipient was prescribed Tegretol (also called carbamazepine) for seizures and behaviors. The Tegretol was prescribed to be administered to the Service Recipient daily at 8:00 a.m., 4:00 p.m. and 8:00 p.m. The Tegretol came in blister packs which were arranged so that each "blister" was an individual dose marked with a number and administered from high number to low number. The lowest numbered doses were marked by a blue background, which alerted staff of the need to reorder the medication. (Justice Center Exhibit 8, Hearing testimony of the Subject and Subject Exhibit F)

8. On [redacted], at 7:30 a.m., the Subject arrived at the [redacted] to begin

her shift. Upon her arrival, the Subject reviewed the communications book and saw a note left by a previous night shift staff, on which she wrote that she administered the last of the Service Recipient's Tegretol. The Subject then reviewed the overflow chart in search of backup medications and found none. The Subject wrote a medication error report on the night shift staff, and then prepared and faxed a note to the [redacted] Pharmacy seeking an emergency refill of Tegretol for the Service Recipient. (Justice Center Exhibit 9, Justice Center Exhibit 23: audio recording of Justice Center interrogation of the Subject and Hearing testimony of the Subject)

9. The Subject telephoned the [redacted] Pharmacy at 9:01 a.m., immediately upon the store's opening, and spoke with the pharmacist. The pharmacist told the Subject that no one from the [redacted] had notified the pharmacy about the medication being low or having run out. A few minutes later, the pharmacist telephoned the Subject and told her that there were no refills remaining on the prescription, and that she had telephoned the Service Recipient's doctor and requested a new prescription. The Subject then faxed a note to both the Service Recipient's neurologist and primary care physician, notifying them that the Service Recipient's Tegretol had run out and requesting that they contact the [redacted] Pharmacy pharmacist. (Justice Center Exhibits 9 and 14, Justice Center Exhibit 23: audio recording of Justice Center interrogation of the Subject and Hearing testimony of the Subject)

10. Having not heard back from the pharmacy, at 1:30 p.m. the Subject telephoned the pharmacist for an update. The pharmacist told the Subject that the prescription would be ready for pick up at around 3:30 p.m. (Justice Center Exhibits 9 and 14, Justice Center Exhibit 23: audio recording of Justice Center interrogation of the Subject and Hearing testimony of the Subject)

11. The Subject wrote a note which stated that the new Tegretol prescription would be ready for pick up that day between 3:00 p.m. and 4:00 p.m. The Subject punched a hole in the

right side of the note and clipped it into the Service Recipient's Medication Administration Record (MAR) and taped it to the MAR page where the staff assigned to administer the next dose of Tegretol at 4:00 p.m. would see it. Staff assigned to medication administration were required to review the MAR at the beginning of their shift, which on [redacted] was 3:30 p.m. (Justice Center Exhibits 2 and 9, Hearing testimony of the Subject and Subject Exhibits C and E)

12. Although the Subject's shift normally ended at 3:30 p.m., she went off duty and left the [redacted] at 2:45 p.m. for previously approved medical leave. (Justice Center Exhibit 9, Justice Center Exhibit 23: audio recording of Justice Center interrogation of the Subject and Hearing testimony of the Subject)

13. The Service Recipient did not receive Tegretol on [redacted] at 8:00 a.m., 4:00 p.m. and 8:00 p.m., as prescribed. The Service Recipient received Tegretol next on [redacted] at 12:00 a.m. (Justice Center Exhibits 7, 10, 12 and 24; and Hearing testimony of the Subject)

14. On [redacted] at 3:50 a.m., the Service Recipient woke up and went to the medication room where he had what appeared to staff to be a seizure. The Service Recipient was thereafter transported to the [redacted] Hospital by ambulance. (Justice Center Exhibits 10, and 12)

15. All staff working at the [redacted] had the authority and obligation to monitor medication levels and refill medication when levels were low. The Subject made it her usual practice to review the medication blister packs of the [redacted] service recipients, determine which medication was low and send refill forms to the pharmacy when medication was low. (Justice Center Exhibit 23: audio recording of Justice Center interrogation of the Subject and Hearing testimony of the Subject)

16. The Subject was out of work on a medical leave from [redacted] until [redacted]. During the Subject's absence, another [redacted] staff assumed the responsibility of monitoring and refilling medication, and should have ordered a refill of the Service Recipient's Tegretol on [redacted], but did not. Additionally, [redacted] staff working on [redacted] and [redacted] failed to order a refill of the Service Recipient's Tegretol, even though they were dispensing medication from the blue area of the blister pack. The Subject was back at work for one week (Monday [redacted] to Friday [redacted]) before the medication ran out. (Hearing testimony of the Subject)

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 abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h) 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 abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category (3), which is defined as follows:

> (c) 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 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.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-20, 22 and 24) The Justice Center also presented an audio recording of the Justice Center Investigator's interview of a witness and interrogation of the Subject. (Justice Center Exhibit 23) The investigation underlying the substantiated report was conducted by [redacted], Justice Center Investigator II, who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf, presented the testimony of one witness and presented six documents. (Subject Exhibits A, B, C, D, E and F)

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject had a custodian's duty to the Service Recipient, that she breached the duty and that her 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. (SSL §488(1)(h))

The Justice Center contends that the Subject had a duty to take appropriate action to ensure that the Service Recipient received his prescribed medication. The Subject contends that, in her position as RN, she had no such duty and, in any event, she took all possible steps to make sure that the Service Recipient's medication was refilled once she learned that it had been depleted.

The record reflects that although all staff at the [redacted] were responsible for monitoring medication levels and any staff could reorder medication when supplies were low, the Subject usually took it upon herself to audit the medication blister packs, determine which medication was

low and send a refill request form to the pharmacy. (Justice Center Exhibit 23: audio recording of Justice Center interrogation of the Subject and Hearing testimony of the Subject) Although monitoring and reordering medication was not part the Subject's official duty as a RN, it is clear that the Subject took on this duty regularly enough that the staff relied on it. Consequently, the Subject had a duty to order the Service Recipient's medication.

The Subject breached this duty by failing to order the medication before it ran out. Although the Subject was off work at the point in time that the medication should have been ordered [redacted], the Subject was back at work for one week (Monday [redacted] to Friday [redacted]) before the medication ran out. The Subject testified that she looked at the Tegretol blister packs weekly to determine if the medication had been depleted to the blue area of the blister pack. (Hearing testimony of the Subject) Had the Subject adhered to her usual practice, she would have reviewed the blister packs during that week, noticed the deficiency and placed the necessary order with the pharmacy.

The Subject argued that she should not be held accountable because other staff had the obligation to recognize that the medication was getting low and the obligation to reorder the medication, and that they should have done so. However, because all staff, including the Subject, were equally authorized and responsible for monitoring medication levels and refilling medication, other staff's failure to carry out their responsibility did not alleviate or negate the Subject's responsibility. Consequently, the Subject's failure to check the level of the Service Recipient's Tegretol and reorder the medication was a breach of her duty.

Although the Justice Center established that the Subject breached a duty that she owed to the Service Recipient, it has not established that the Subject's breach of duty resulted in actual physical injury or serious or protracted impairment of the physical, mental or emotional condition

of the Service Recipient.

The evidence presented by the Justice Center is inconclusive on the issue of whether or not the Service Recipient suffered actual impairment as a result of missing three doses of Tegretol. The hospital physician opined that the Service Recipient suffered a seizure and that the seizure was most likely a result of missing his doses of Tegretol during the previous day. (Justice Center Exhibit 10) However, the Service Recipient's primary care physician was ambivalent on this issue and deferred to the Service Recipient's neurologist. (Justice Center Exhibit 17) The Service Recipient's neurologist opined that the three missed doses of Tegretol did not cause the Service Recipient to have a seizure and that the Service Recipient did not suffer a seizure, but instead had an episode of automatism: an unconscious movement that may resemble simple repetitive tics. (Justice Center Exhibit 18) There is no compelling evidence in the record that the Service Recipient's condition was caused by missing three doses of Tegretol. There is no other evidence in the record that the Service Recipient suffered any actual impairment as a result of missing three doses of Tegretol.

However, the Justice Center did establish that the Service Recipient was likely to suffer physical injury or the serious or protracted impairment of his physical condition as a result of missing three doses of Tegretol. The record reflects that the medication was prescribed for the Service Recipient as a medical remedy for seizures and the Service Recipient's behavior. Although the Service Recipient's last known seizure was in 1987 (Justice Center Exhibit 17), the record reflects that the Service Recipient has had seizures in the past as a result of his medications being stopped. (Justice Center Exhibit 10) Because the Tegretol was prescribed in part to remedy the Service Recipient's seizures, the Justice Center has established that the Subject's failure to timely reorder the Tegretol, which resulted in the Service Recipient missing three doses of the

medication, was likely to result in physical injury or serious or protracted impairment of the Service Recipient's physical condition.

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.

Substantiated Category 3 findings 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 SSL § 496 (2). The report will be sealed after five years.

DECISION: The request of [redacted] that the substantiated report dated [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 John T. Nasci, Administrative Hearings Unit.

DATED: January 23, 2017
Schenectady, New York

John T. Nasci, ALJ