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: Juliane O'Brien, Esq.

[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 two substantiated reports dated [redacted], [redacted] and [redacted] be amended and sealed, is hereby denied. In each case, the Subject has been shown by a preponderance of the evidence to have committed neglect.

Both of the substantiated reports are properly categorized, as Category 2 acts.

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: February 23, 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 Numbers: [redacted]

Before: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: Administrative Hearing Unit
New York State Justice Center
1200 East & 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
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[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains two reports substantiating [redacted] (the Subject) for neglect. The Subject requested that the VPCR amend the reports to reflect that the Subject is not a subject of these substantiated reports. 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 two "substantiated" reports, dated [redacted], [redacted] and [redacted], [redacted] which involved alleged acts of neglect by the Subject of a service recipient.

2. The Justice Center substantiated two separate reports for neglect by the Subject regarding the care of Service Recipient A and Service Recipient B. The Justice Center concluded as follows:

[redacted] Report of Substantiated Finding (Service Recipient A):

[redacted]

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 ensure that appropriate safeguards were put into place in response to a service recipient's increased fall frequency, failed to convene a formal treatment team meeting after repeated falls, failed to appropriately update the service recipient's IPOP[1], failed to ensure that essential assistive equipment was purchased and maintained, and failed to timely train staff members on the use of essential assistive equipment.

[1] IPOP means Individual Plan of Protection.

As to any portion of this allegation occurring prior to June 30, 2013, the Justice Center does not have jurisdiction to make a finding. The portion of this allegation occurring after June 29, 2013, has been SUBSTANTIATED as Category 2 neglect, pursuant to Social Services Law §493(4)(b)

[redacted] Report of Substantiated Finding (Service Recipient B):

[redacted]

Allegation 1

It was alleged that on or about and between [redacted] and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to ensure that appropriate safeguards and protective measures were put into place, and that adequate responses were undertaken, after a service recipient had a series of falls that resulted in him being diagnosed with an acute/subacute fracture of his spine. Your conduct included: allowing staff to place a bed alarm that was known to be malfunctioning on the bed of the service recipient, failing to ensure that assistive and other equipment was promptly purchased and maintained, that the service recipient's IPOP was updated, and that staff was trained and/or instructed on use of assistive and other equipment and on how to respond appropriately to the service recipient's falls.

These allegations have been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law §493(4)(b).

3. An Administrative Review was conducted and as a result both of the substantiated reports were retained.

4. The facility, known as the [redacted], is located at [redacted]. This [redacted] provides residential services to persons diagnosed with Alzheimers and/or dementia and other disabilities. The facility is operated by [redacted] and is certified by the New York State Office for People With Developmental Disabilities (OPWDD), a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Justice Center Investigator [redacted] and Justice Center Exhibit 16)

5. The Subject had been employed by [redacted] as the [redacted] full-time

Residential Coordinator since [redacted] 2009 and regularly visited the facility. (Hearing testimony of the Subject) The Subject was a custodian of both Service Recipients as that term is so defined under SSL § 488(2).

6. Generally, the Residential Coordinator's duties involved the supervisory oversight of the [redacted] and ensuring that the facility followed all agency policies and procedures. The Subject's supervisory oversight included, but was not limited to the direct supervision of the [redacted] residential manager, ensuring that Plans of Protective Oversight (POPOs) and Individual Plans of Protective Oversight (IPOPs) were properly updated, that residential services were properly provided, evaluating site safety, assessing staff training requirements and then commutating those needs to the training department. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 8, 10 and 12-14 under [redacted]; and Justice Center Exhibits 9, 11 and 13-15 under [redacted])

7. During the time of the alleged neglect pertaining to [redacted] and [redacted], not all of the facility staff had been trained in the use of every type of assistive equipment that was necessary for the proper care of Service Recipient A and Service Recipient B. At some point, the facility nurse conducted in-service trainings regarding the proper use of assistive equipment such as, the Hoyer lifts (mechanical and manual), bed and chair alarms, gait belts and walkers.[2]

8. During the relevant time, the Subject failed to initiate a protocol for facility staff to follow should the service recipients' assistive equipment failed. (Hearing testimonies of Subject, Residential Manager, [redacted] (the facility's Registered Nurse, hereinafter referred to as RN) and

[2] At the hearing, former facility RN testified that she had conducted in-service staff trainings on the facility's assistive equipment but did not recall when the training was held. The record is unclear as to when the trainings were held, which staff attended and which staff did not. Justice Center Investigator [redacted] testified that during the course of the investigation although she made efforts to do so, she could not obtain relevant training records and sign-in sheets.

Justice Center Investigator [redacted]; Justice Center Exhibits 8-9, 15, and 61-62 and 76 of [redacted] and Justice Center Exhibits 9-10, 16, 62-63 and 73 of [redacted])

Facts pertaining to [redacted] Substantiated Report - Service Recipient A

[redacted]

9. At the time of the alleged neglect, Service Recipient A was a sixty-six year old male who had been a resident of the facility since [redacted]. Service Recipient A was a person with diagnoses of cerebral palsy, mild cognitive impairment, type 2 diabetes, diabetic (foot) neuropathy, anxiety disorder, obsessive-compulsive disorder and other medical conditions. (Justice Center Exhibits 8, 60, 63-73 of [redacted])

10. In [redacted], Service Recipient A, who had a history of falling, walked with an unsteady gait due to his diabetic foot neuropathy. In the event of a fall where Service Recipient A could not get himself up, his general IPOP, last updated on [redacted], only required staff to call the on-call nurse for directives and provided no detailed instructions as to how to respond to his falls. However, it was common practice for staff to lift him from the floor using the mechanical Hoyer lift in part due to the nurse's directives. (Hearing testimonies of Residential Manager, RN and Justice Center Investigator [redacted]; Justice Center Exhibits 8, 20-21, 61 of [redacted])

11. Service Recipient A's IPOP also required "arms-length" staff assistance when he tried to stand or ambulate, since he often attempted to toilet without calling for staff assistance. Service Recipient A's daily assistive equipment included, but was not limited to a bed and chair alarm, baby monitor, gait belt, walker, wheelchair and Hoyer lift. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 8, 16, 61-62 and 74 of [redacted]

12. In [redacted], Staff [redacted] (Residential Manager) was promoted from Direct Support Professional (DSP) to the facility's Residential Manager. However, the Residential Manager received no formal training for this position until [redacted]. (Hearing testimony of the Residential Manager; Justice Center Exhibits 8, 10, 12, 37, 76 of [redacted] and Subject's Exhibit C)

13. Service Recipient A's falls became so frequent that, by [redacted], he had fallen approximately fourteen times in that year. Service Recipient A fell twice on [redacted] requiring stiches in his head. Service Recipient A also experienced three falls in the month of [redacted] and three falls in the month of [redacted]. (Justice Center Exhibits 8 and 40-53 of [redacted])

14. On [redacted], at approximately 3:00 a.m., Service Recipient A fell from his bed onto the floor. This fall was his fourteenth fall in [redacted]. The bed alarm[3] did not activate when Service Recipient A arose from his bed and fell. When Service Recipient A yelled for staff assistance, staff heard him through the baby monitor located in his bedroom. (Hearing testimony of the Residential Manager; Justice Center Exhibits 8, 40-55, 57-58 and 76 of [redacted]

15. Staff was unable to use mechanical Hoyer lift to assist Service Recipient A because it was inoperable due to a dead battery and the power cord could not be found. Two staff persons then detached the mesh seat from the Hoyer lift and used it to manually lift Service Recipient A

[3] Service Recipient A's bed alarm was weight released activated through a bed sensor mat that Service Recipient A laid on. The bed alarm set up included a box on his bed that was connected to a power cord that was plugged into the wall outlet. The alarm was supposed to activate to alert staff each time Service Recipient A got out of his bed. This particular alarm was designed in a manner such that it had a five second delay from when Service Recipient A's weight was released from the bed sensor mat to the actual activation of the alarm. (Hearing testimonies of the Residential Manager and Justice Center Investigator [redacted]; Justice Center Exhibits 8 and 38 of [redacted])

from the floor onto his bed. Service Recipient A's most recent IPOP, dated [redacted][4], did not address staff protocols for equipment failures and his daily use of assistive equipment. (Hearing testimonies of the Residential Manager and Justice Center Investigator [redacted]; Justice Center Exhibits 8, 20, 33, 53, 55 and 76, audio interviews of the Subject and Residential Manager of [redacted])

16. The following day, Service Recipient A was hospitalized, diagnosed with right hip and knee fractures which ultimately necessitated surgery. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 58 and 64-73 of [redacted])

17. On [redacted], by way of a Therap note, a Residential Trainer updated Service Recipient A's IPOPs to include his use of a gait belt.[5] However, none of Service Recipient A's prior IPOPs, or this update, fully addressed his gait belt needs, provided staff with instructions as to how to use the gait belt, mentioned his Dementia diagnosis, listed all of the daily assistive equipment used by him or instructed staff where his walker should be placed. Additionally, Service Recipient A's IPOPs did not provide adequate fall protective measures, and only addressed preventing falls when he ambulated, without addressing fall risks in other circumstances such as, when he arose from his bed or exited a vehicle. (Justice Center Exhibits 8, 35 and 56 of [redacted])

18. On [redacted], staff was trained by the Subject and Residential Manager to ensure that Service Recipient A's walker was placed within arm's length of him at all times. On [redacted], the above noted deficiencies in Service Recipient A's IPOPs were

[4] The record does not contain a copy of Service Recipient A's [redacted] IPOP. However, the record does contain related documents and OPWDD's Statement of Deficiencies which discusses the contents of the [redacted] IPOP in detail. Also, the record contains Service Recipient A's general IPOP updated on [redacted] and his residential IPOP which was updated on [redacted]. (Justice Center Exhibits 33-35 and 61-62 of [redacted])

[5] A copy of the Service Recipient's IPOP updated on [redacted] is not included in the record for [redacted].

corrected and the Subject implemented an adequate and complete fall prevention plan for him. (Justice Center Exhibits 8, 34-35, 40-56, 61-62, 74 and 76 of [redacted])

19. Ultimately, following the [redacted] surgery, Service Recipient A was transferred to a rehabilitation center then re-admitted to the hospital, where he died. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 58 and 64-73 of [redacted])

Facts pertaining to [redacted] Substantiated Report - Service Recipient B

[redacted]

20. At the time of the alleged neglect, Service Recipient B was a sixty year old male who had been a resident of the facility since at least [redacted] 2012. Service Recipient B was diagnosed with moderate intellectual disability, Down syndrome, seizure disorder, depression, dementia/Alzheimer's disease, anxiety, stroke, mild hearing loss in left ear and other medical conditions. (Justice Center Exhibits 8 and 64-68 of [redacted])

21. On [redacted], Service Recipient B fell and was found by staff lying on the bathroom floor in a "deep sleep" and "not responding" to staff's questions. Service Recipient B was transported and admitted to the hospital. The hospital performed a Computed Tomography (CT) scan of Service Recipient B's head. Thereafter, Service Recipient B was hospitalized for twenty-four hours, then discharged and returned to the facility. (Justice Center Exhibits 33 and 36-37 of [redacted])

22. On [redacted] at 6:00 a.m., Service Recipient B fell a second time in his bedroom. Staff heard a "thump" and upon investigation found Service Recipient B lying "face down" on the floor. Service Recipient B was "shaking," "snoring loudly" and sustained an injury, described as a "golf ball size raised area" on his left forehead. After the on-call nurse arrived and

applied ice to Service Recipient B's injury, she gave further instructions to staff and advised that Service Recipient B needed a bed alarm. Service Recipient B was capable of consenting to his own medical treatment and declined to be transported to the hospital for further evaluation of his injuries. (Justice Center Exhibits 34, 38, 65 and 67 of [redacted])

23. At 4:40 p.m. on [redacted], the Residential Manager created a "Therap" note (or "T-log") in the staff's computerized communication system. The note instructed staff to move Service Recipient B's bed against the wall and to install Service Recipient A's malfunctioning bed alarm onto Service Recipient B's bed. After the task of transferring the bed alarm was completed, a staff person entered a Therap note stating that she had tried "…every trick in the book to get it to work, but the broken bed alarm remains a broken bed alarm." Thereafter, the bed alarm continued to malfunction. Staff was further directed to track the bed alarm's functionality by making entries in Therap and the Device Maintenance Book.[6] (Hearing testimony of the Residential Manager; Justice Center Exhibits 9 and 39-42 of [redacted] regarding Service Recipient B and Justice Center Exhibit 8 of [redacted] regarding Service Recipient A)

24. The next day, staff transported Service Recipient B to a medical facility where he underwent a CT head/brain scan that revealed no significant change from the previous CT scan. (Justice Center Exhibits 9, 43 and 65 of [redacted])

25. On [redacted], four days after staff moved Service Recipient B's bed against the wall, Service Recipient B fell out of his bed for a third time. (Justice Center Exhibits 9 and 72 of [redacted])

[6] As previously discussed, Service Recipient A's bed alarm was known by staff to have a five second delay, worked intermittently and frequently malfunctioned. (Hearing testimonies of the Subject, Residential Manager and Justice Center Investigator [redacted]; Justice Center Exhibits 9 and 73 of [redacted])

26. During the early morning hours of [redacted], Service Recipient B fell out of bed for a fourth time. Staff heard a loud sound, then the bed alarm initiated. Service Recipient B was found lying on the floor between his bed and the nightstand. As a result of the fall the Service Recipient struck his head on the floor and sustained a "dime size bruise" under his left eye. (Justice Center Exhibits 9, 35 and 67 of [redacted])

27. Later in the morning of [redacted], Service Recipient B was evaluated by a medical practitioner who concluded that he had experienced a decline in neurological function that might be attributable to his recent multiple falls and head injuries. (Justice Center Exhibits 9, 35, 46-47 and 66-67 of [redacted])

28. On [redacted], Service Recipient B nearly fell again for a fifth time. Service Recipient B lost his balance after he exited a vehicle while on the way to a hospital medical appointment. Staff caught Service Recipient B before he hit the ground and transported him by wheelchair into the hospital for his appointment. However, the medical appointment was canceled because he could not stay awake and Service Recipient B was immediately transferred to the hospital's emergency room where CT scans of his head/brain and cervical spine were performed. At that time, Service Recipient B was noted to have neck fractures and was provided with a neck brace and then transferred to a different hospital for a consultation with a spine specialist. (Justice Center Exhibits 7, 9, 48-49 and 61, 63-73 of [redacted])

29. On [redacted], Service Recipient B was released from the hospital and returned to the facility. By this time, a draft fall prevention plan had been implemented and an outside vendor had replaced the malfunctioning bed alarm power cord. Additionally, on this same date, Service Recipient B's general and residential IPOPs were updated to include the use of a baby monitor and the direction that staff was to remain in close proximity when the Service

Recipient B ambulated. (Justice Center Exhibits 9, 51 and 53-54 of [redacted])

30. On [redacted], Service Recipient B had another CT scan of his head/brain. The CT scans performed on [redacted] and [redacted] revealed that Service Recipient B had fractures in his spine at the C1 and C7 levels and that the "… fractures . . . [were] acute sub-acute in age…" (Justice Center Exhibits 7-9, 21, 49, 55 and 63-73 of [redacted])[7]

31. Finally, on [redacted], two new wireless bed alarms were purchased by the facility. One of the new bed alarms was installed onto Service Recipient B's bed. The other new bed alarm served as a backup. (Hearing testimony of the Residential Manager; Justice Center Exhibits 32 and 73, audio interview of Residential Manager of [redacted])

32. On [redacted], a special incident review committee meeting was held to review fall prevention or protective measures undertaken for Service Recipient B to address his frequent falls. By that time, the draft fall safety prevention plan had been properly revised, completed and implemented by the Subject. (Justice Center Exhibit 61 of [redacted])

[7] It should be noted that Service Recipient B's CT scan of his head/brain on [redacted], was performed when he was hospitalized following a seizure while sitting on the toilet and was found unresponsive. The [redacted] head/brain scan showed "old" fractures but that the fractures were "acute sub-acute in age," which meant that they were unable to determine if this was a new fracture to correlate clinically with a finding relative to the Service Recipient B's history. (Justice Center Exhibits 69-72 of [redacted])

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 reports.
- Whether the substantiated allegations constitute neglect.
- Pursuant to Social Services Law § 493(4), the category of 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 reports of abuse and neglect presently under review were 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. Under SSL § 488(1)(h) neglect is defined as:

> "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)(b), including Category 2, which is defined 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 by a preponderance of the evidence that the Subject committed the acts of neglect alleged in both substantiated reports and that such acts constitute the category of neglect as set forth in those reports. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged neglect, the reports 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 acts of neglect cited in the two substantiated reports constitute the category of neglect as set forth in the substantiated reports.

If the Justice Center did not prove the neglect by a preponderance of evidence, the substantiated reports must be amended and sealed.

Discussion Regarding [redacted] Report (Service Recipient A)

[redacted]

The Justice Center has established by a preponderance of evidence that the Subject committed the prohibited acts, described as "Allegation 1" in the substantiated report under [redacted].

In support of its substantiated findings as to [redacted], the Justice Center presented a number of documents obtained during the investigation that were received into

evidence. (Justice Center Exhibits 1, 3, 5-28, 30-38, 40-75 and 76, an audio CD which included Service Recipient A's interview under [redacted])[8]

The investigation underlying this substantiated report was conducted by Justice Center Investigator [redacted], who testified at the hearing on behalf of the Justice Center. The facility's former Residential Manager and former Registered Nurse (RN) also testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and offered written documentation that was received into evidence as Subject's Exhibits A through C.

The Justice Center contends in Allegation 1 of the substantiated report dated [redacted] that, from [redacted] through [redacted], the Subject committed neglect by her conduct and oversight of the facility with regard to Service Recipient A's care, which ultimately lead to him sustaining serious injuries. (Justice Center Exhibit 1 of [redacted])

A finding of neglect requires, in part, that a preponderance of the evidence establishes that, with respect to the Subject's oversight of the facility, the Subject engaged in conduct that breached her custodial duty to the Service Recipients. In this case, as the facility's Residential Coordinator and direct supervisor of the Residential Manager, the Subject had a duty to ensure that an adequate safety fall prevention plan was implemented for Service Recipient A and that appropriate safeguards were established in response to his increased frequency of falling. The Subject also had a duty to timely convene a formal treatment team meeting to address Service Recipient A's

[8] At the hearing, Justice Center Exhibits 40, 41 and 45 of [redacted] were admitted into evidence over the Subject's objection for the limited purpose of establishing the facility's knowledge of Service Recipient A's falls that occurred prior to the Justice Center's jurisdiction on June 30, 2013. Justice Center Exhibits 2, 4, 29 and 39 were withdrawn under [redacted].

falls, ensure that Service Recipient A's Individual Plan of Protection (IPOP) was properly updated, ensure that assistive equipment was timely purchased and properly maintained, and to ensure that staff was properly trained in the use of assistive equipment needed for Service Recipient A's care. The Subject's oversight failures were also addressed as part of OPWDD DQI's Statement of Deficiencies and the [redacted] responses to such deficiencies under the [redacted] proposed Plan of Corrective Action (POCA). (Hearing testimonies of the Subject, Justice Center Investigator [redacted], Residential Manager, RN; Justice Center Exhibits 1, 7-10, 12-28, 30-38, 40-76, audio interviews of staff[9] of [redacted] and Subject's Exhibits A-C)

At the hearing, the Subject denied the allegation. The Subject testified that she was aware that Service Recipient A fell more often due to his diabetic foot neuropathy, that any staff member had the ability to call a treatment team meeting and that, as the Residential Coordinator, she regularly visited the facility. The Subject also acknowledged that she had access to Therap notes, reviewed service recipients' IPOPs and provided staff with instructions as to how to implement the IPOPs. The Subject also testified that Service Recipient A's falls were discussed at the first treatment team meeting convened on [redacted], the same date of his fall; however, she did not recall who called the meeting and the record remains unclear on this issue. Additionally, the Subject's hearing testimony re-iterated what she had said during her interrogations on [redacted] and [redacted]. The Subject testified that she knew that Service Recipient A's bed alarm did not always function correctly and that she chose to arrange to have the bed alarm repaired two times instead of purchasing a new one. During his hearing testimony, the Residential Manager

[9] It should be noted that in his second interview on [redacted], the Residential Manager admitted that he was afraid of losing his job and that he was initially untruthful to Justice Center Investigator [redacted] during his first interview on [redacted]. To correct what he first reported, he explained that he believed that the supervisors were neglectful in the operation of the facility and for their failure to provide proper equipment for Service Recipient A even though staff had asked them to do so. (Hearing testimony of Residential Manager and Justice Center Exhibit 76 of [redacted])

corroborated that the Subject and her superior, the Residential Director, both knew that Service Recipient A's bed alarm was defective. (Hearing testimonies of the Subject and the Residential Manager; Justice Center Exhibits 8 and 76, audio interrogation of the Subject under [redacted] and Subject's Exhibit C)

Service Recipient A's Untimely and Inadequate Fall Prevention Plan

No Convening of Treatment Team Meeting to Address Increase of Fall Frequency

It is should be noted that there exists overlapping and common evidence involving Service Recipient A's and Service Recipient B's care at the facility. The record establishes that Service Recipient A had about five falls prior to his IPOP being updated on [redacted]. Service Recipient A then fell approximately nine more times from [redacted] up to his fall on [redacted] when he was hospitalized and diagnosed with right hip and knee fractures which required surgery. During his [redacted] investigatory interview, Service Recipient A stated that his walker was not within reaching distance at his bedside and that he fell on [redacted] trying to access the walker. (Hearing testimonies of the Subject and Justice Center Investigator [redacted]; Justice Center Exhibits 10 and 63-73 and 76, an audio CD containing Service Recipient A's interview under [redacted])

Yet, in spite of the Subject's knowledge of Service Recipient A's foot neuropathy diagnosis that caused him to be a higher fall risk and the increased frequency of his falls, the record shows that the Subject did not timely implement an adequate safety fall prevention plan for Service Recipient A. In fact, the draft or initial fall plan for Service Recipient A that was implemented on [redacted] (about fourteen falls later) was inadequate in that it only established a fall plan when Service Recipient A ambulated, did not address other fall risk situations, such as when he arose from his bed or exited a vehicle, and did not list all of the daily assistive equipment he needed

to use. The Subject's initial fall plan was later properly revised on [redacted] and finally implemented on [redacted].[10] (Justice Center Exhibits 34-35, 61-62 and 74 of [redacted])

Additionally, the record illustrates that the Subject knew that she had the ability to call a treatment team meeting to timely address Service Recipient A's increased falls, but failed to do so. On [redacted], Service Recipient A fell again at the facility for the fourteenth time that year. He was hospitalized with right hip/knee fractures and never returned to the facility. Finally, on that same date, the first treatment team meeting was held to address Service Recipient A's falls. Given the escalation of falls and injuries, coupled with the Subject's authority and job responsibilities, the Subject had a duty to initiate a treatment team meeting after each fall. At the treatment team meeting, additional fall prevention options could have been explored, considered and established, such as the implementation of one-to-one supervision or similar enhanced supervision to protect Service Recipient A. (Hearing testimonies of the Subject and Justice Center Investigator [redacted]; Justice Center Exhibits 8, 23, 26, 33 35 61-62 of [redacted])

Failure to Properly Update Service Recipient A's IPOPs

The evidence further establishes that Service Recipient A's IPOPs were updated on [redacted][11], [redacted] (general) and [redacted] (residential). Nonetheless, at the time of the Service Recipient's fall on [redacted], the IPOPs failed to address the complete scope preventative measures necessary to address the falling. The IPOPs and their updates failed to list the following: Service Recipient A's dementia diagnosis; all of the assistive equipment used by

[10] It should be noted that although a draft fall prevention plan was eventually implemented then subsequently revised, Service Recipient A never returned to the facility after his hospitalization for the [redacted] fall.
[11] Refer to footnote 5 supra.

staff daily in his care (such as his gait belt); why the equipment was needed (such as the gait belt being needed to stabilize his gait); and how the equipment was to be used (such as his walker to always be placed within arm's reach, especially at night; and the use of his wheelchair for distances); staff protocols during equipment malfunctions; proper staff supervisory levels and other matters. Consequently, the Subject breached her duty to Service Recipient A and failed to take appropriate action to ensure that Service Recipient A's IPOPs were properly updated as discussed above. (Justice Center Exhibits 8, 15, 33, 35 and 61-62 of [redacted])[12]

Failure to Purchase/Maintain Assistive Equipment and Timely Train Staff

The record establishes that the Subject failed to ensure the purchase and maintenance of assistive equipment needed for Service Recipient A's care, and to ensure staff was properly trained as to how to use the assistive equipment. The Subject testified that, despite her knowledge that the Service Recipient's bed alarm was malfunctioning, she chose to have Service Recipient A's bed alarm repaired on [redacted] and [redacted], instead of purchasing a new one. Despite the repairs, the alarm continued to malfunction and Service Recipient A fell for the fourteenth time on [redacted] sustaining serious injuries. The Subject had a duty to ensure and verify that Service Recipient A's bed alarm was functioning at all times, but failed to do so. (Hearing testimonies of Subject, Residential Manager and RN; Justice Center Exhibits 8, 16-17, 25, 28, 55, 61-62 and 76, audio interview of the Residential Manager under of [redacted])

The record also establishes that the mechanical Hoyer lift malfunctioned due to a dead battery and no back up battery or power cord was available to staff after Service Recipient A fell

[12] Refer to footnote 9 supra.

on [redacted]. Moreover, the Subject had no protocol or instructions in place to guide staff as to what to do in the event that essential assistive equipment, such as the Hoyer lift, was to malfunction. The Subject had a duty to ensure that the mechanical Hoyer lift was operational at all times, and that a functional back up was available to staff. The Subject also had a duty to implement a protocol to guide staff as to what to do in the event equipment malfunctioned. (Hearing testimonies of the Subject, Residential Manager, RN and Justice Center Investigator [redacted]; Justice Center Exhibits 8, 16-21, 28, 34 and 76, audio interview of Residential Manager under of [redacted])

Regarding the lack of staff training, the RN testified at the hearing that she conducted in-service trainings for all staff as to how to use the assistive equipment, including the Hoyer lift, but she did not recall when she held the trainings or which staff persons attended. However, the Residential Manager provided credible testimony that not all staff were trained in the use of the Hoyer lift. Staff investigatory interviews and interview notes corroborated the Residential Manager's testimony that some staff were not trained as to how to use the Hoyer lift and that the lack of training had been a chronic issue at the facility. (Hearing testimony of the Residential Manager; Justice Center Exhibits 8, 21, 28, 35 and 76 of [redacted])

The ALJ presiding over the hearing having considered the evidence and evaluated the RN's hearing testimony finds that part of the RN's testimony regarding the training of all staff on the facility's assistive equipment, especially the Hoyer lift is not credited evidence. Additionally, it is further found that the Justice center has established by a preponderance of the evidence that not all staff received appropriate training on the use of assistive equipment, including the Hoyer lift. The Subject had a duty to ensure that all staff were trained how to use the assistive equipment, including that equipment used in the care of Service Recipient A; however, she did not. (Hearing testimonies

of the Residential Manager, facility nurse; Justice Center Exhibits 8, 10, 12-13, 26, 28 and 37 of [redacted])

II

Discussion Regarding [redacted] Report (Service Recipient B)

[redacted]

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 dated [redacted] under [redacted].

The Justice Center presented a number of documents obtained during the course of the investigation. In support of its substantiated findings as to [redacted], the Justice Center's Exhibits 1 through 22, 24 through 72 and 73, an audio CD, were all received into evidence.[13]

The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who testified at the hearing on behalf of the Justice Center. The facility's former Residential Manager and former RN also testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and provided written documentation, which was received into evidence as Subject's Exhibits A through C.

The Justice Center contends in Allegation 1 of the substantiated report dated [redacted] that the Subject committed neglect by her conduct and lack of oversight of the facility with regard to Service Recipient B's care during the period of [redacted] through [redacted]. (Justice Center Exhibit 1 of [redacted])

[13] At the hearing, the Justice Center withdrew Exhibit #23 of [redacted].

The record establishes by a preponderance of the evidence that, as the facility's Residential Coordinator, the Subject had a duty to ensure that appropriate safeguards and protective measures were implemented and that adequate responses were undertaken after Service Recipient B had a series of falls; however, the Subject breached her duty.

Failure to Ensure Appropriate Safeguards and Implement Protective Measures

The record illustrates that Service Recipient B's falls steadily increased in [redacted], with two falls in [redacted] and three falls in [redacted], yet the Subject did not act to implement a proper fall plan until she established an incomplete draft fall plan in [redacted]. By that time, Service Recipient B had already sustained serious injuries. (Hearing testimonies of Subject and Justice Center Investigator [redacted]; Justice Center Exhibits 9, 33-34, 37-38, 49, 51-53, 65, 69-71 and 73 of [redacted])

The record also establishes that the Subject failed to ensure that the facility's responses to Service Recipient B's falls were timely, adequate or proper. In response to Service Recipient B's fall on [redacted], the Residential Director issued a directive that was implemented by the Residential Manager's [redacted] Therap note. The directive required staff to move Service Recipient B's bed against the wall, remove the defective bed alarm from Service Recipient A's bed and install it onto Service Recipient B's bed, conduct 10 minute bed checks and place a mat in front of Service Recipient B's bed to mitigate fall injuries. The instruction to install the malfunctioning bed alarm onto Service Recipient B's bed was improper. Additionally, staff directives or protective measures addressed in the Therap note were not added to Service Recipient B's IPOP by the Subject, Residential Manager or any other staff until [redacted], nine days after his [redacted] fall.

Moreover, Service Recipient B's residential IPOP created on [redacted] was

updated on [redacted], then again on [redacted].[14] However, these IPOP updates failed to fully reflect Service Recipient B's current needs related to his falls (such as bed checks), lacked a fall protocol for staff to follow, failed to list all of his medical diagnoses (such as dementia), failed to list all assistive equipment staff used daily in his care (such as his baby monitor) and lacked an explanation as to why such equipment was essential. Service Recipient B's IPOP was not updated to include instructions to staff to remain in close proximity when Service Recipient B ambulated, until [redacted], when he had been diagnosed with neck fractures. Service Recipient B's safety fall protection plan had not been confirmed as adequate and fully implemented until the special incident review committee meeting was held on [redacted], well after he had fallen multiple times and sustained serious injuries. (Justice Center Exhibits 9, 16, 54 and 61-63 of [redacted])

The Subject testified that she did not know Service Recipient A's defective bed alarm was installed onto Service Recipient B's bed. However, this part of the Subject's testimony is not credited evidence. As the Residential Coordinator, the Subject monitored the facility and conducted regular site visits with access to staff Therap notes. The Subject should have been able to access the Residential Manager's [redacted] Therap note to staff instructing them to switch Service Recipient A's malfunctioning bed alarm to Service Recipient B's bed. It was her responsibility to oversee the facility and supervise the Residential Manager. Even though the original directive to transfer the defective alarm came from the facility's Residential Director, the Subject should have been aware of the defective bed alarm transfer and prevented it by addressing the issue directly with her supervisor, the Residential Director or the Residential Director's

[14] The general POPO dated [redacted] referred to in the record is not specific to Service Recipient B and is applicable to all facility residents. The record is unclear as to when an update was made to the general IPOP. (Justice Center Exhibit 15 of [redacted] and Justice Center Exhibit 16 of [redacted])

superior. However, the Subject did not. (Hearing testimonies of the Residential Manager and the Subject; Justice Center Exhibits 9, 11, 22, 39 and 40 of [redacted])

The Subject also testified that she had the malfunctioning bed alarm repaired on two occasions. The evidence shows that, during the relevant time, no repair was made until [redacted]. At that time, the vendor making the repairs to the broken bed alarm provided the facility with a temporary loaner bed alarm. It appears that the loaner bed alarm was used until the new bed alarm system, purchased on [redacted], could be installed on Service Recipient B's bed. On that same date, a second bed alarm was purchased to be used as a back-up bed alarm. (Justice Center Exhibits 9, 32 and 53 of [redacted])

The record also establishes that the Subject failed to ensure that staff were properly trained in the use of assistive equipment prescribed for use by the Service Recipients. Since this issue has already been addressed in detail above in the discussion regarding Service Recipient A's assistive equipment, it will not be re-iterated here. Although the Subject testified that she usually provided specific instructions to staff within the IPOPs themselves, there were no such instructions in Service Recipient B's IPOPs directing staff on appropriate responses to his falls. (Hearing testimonies of the Subject, Residential Manager, Justice Center Investigator [redacted]; Justice Center Exhibits 8-9, 16 and 73 of [redacted])

Subject's Defenses As to Both Substantiated Reports

At the hearing the Subject testified that under the circumstances, she did the best job she could in light of available resources and the systematic failures at the [redacted]. The Subject testified unconvincingly and the proof did not corroborate that it was the Residential Manager who was wholly responsible for updating the Service Recipient's IPOP, especially given that the Residential Manager had been untimely trained as to his job duties. (Hearing testimonies of the Subject and

Residential Manager; Justice Center Exhibit 76, audio interview of the Subject under [redacted] and Subject's Exhibits A-C)

The Subject also testified that there were periods of time when she was absent from the facility and some days where she worked less than full time. A review of the Subject's time sheets corroborates that during the relevant time, there were days where the Subject worked less than full time. However, the number of days worked less than full time was insignificant and there were numerous days where she had worked overtime. The time sheets also illustrated that the Subject did use leave time and was absent from the facility from [redacted] through [redacted]. However, since the Subject's time cards do not reflect the name of the facility she was working at from [redacted] through [redacted], she lacks corroborating documentation to support her claim that during this time frame she had been transferred to work at a different group home.

Even if the Subject's transfer claim is credited, considering that she had been the [redacted] full-time Residential Coordinator since 2009, a one-month absence from the facility is an insignificant period and does not absolve her of responsibility for the [redacted] failures involved here. The Subject was responsible for overseeing the [redacted] and to directly supervise the Residential Manager. Consequently, the Subject was the one in the best position to have corrected the relevant [redacted] failures; however, she did not. (Hearing testimony of the Subject, Subject's Exhibits A-C; Justice Center Exhibit 8 of [redacted] and Justice Center Exhibit 9 of [redacted])

After weighing the evidence, it is determined that the Subject breached her facility oversight duties. As such, the Subject's conduct constituted a breach of her custodial duty to the Service Recipients to ensure that appropriate safeguards and protective measures were implemented. The evidence established that the Subject's conduct resulted in or was likely to have

resulted in physical injury or serious or protracted impairment of the physical, mental or emotional condition of both Service Recipients.

Accordingly, as to both of the substantiated reports, 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 as alleged. The substantiated reports will not be amended or sealed.

Although each of the two reports will remain substantiated, the next question to be decided is whether both of the substantiated reports constitute the category of neglect as set forth in the substantiated reports. Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, there is a preponderance of the evidence to conclude that the Subject's neglect seriously endangered the health, safety or welfare of Service Recipient A and Service Recipient B. Therefore, it is determined that the two substantiated reports are properly categorized as Category 2 acts.

These two substantiated Category two findings 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 two finding that have not been elevated to a Category one finding shall be sealed after five years.

DECISION: The request of [redacted] that the two substantiated reports dated [redacted], [redacted] and [redacted] be amended and sealed, is hereby denied. In each case, the

Subject has been shown by a preponderance of the evidence to have committed neglect.

Both of the substantiated reports are properly categorized, as Category 2 acts.

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

DATED: February 6, 2017
West Seneca, New York