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]

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: March 30, 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 Office Building
207 Genesee Street, Room 103D
Utica, New York 13501
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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By: Laurie Cummings, Esq.

[redacted]

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 an overnight shift between [redacted] and [redacted], while at the [redacted] Hospital and away from [redacted], located at [redacted], while a custodian, you committed neglect when you fell asleep or were less than alert while on duty, during which time a service recipient was not properly supervised and/or during which time the service recipient's oxygen mask did not remain on.
>
> 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 an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted], Justice Center Investigator II)

5. At the time of the alleged neglect, the Subject was employed by the OPWDD as a Developmental Assistant 1 (DA1) and had been employed by the OPWDD for ten years. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was forty years old. The Service Recipient was an adult male with diagnoses of Down syndrome, profound mental retardation, developmental delay, and hearing impairment. (Justice Center Exhibits 12, 13 and 14)

7. The Service Recipient was admitted to [redacted] Hospital (the hospital) on [redacted], and diagnosed with pneumonia. While in the hospital, the Service Recipient required the constant administration of oxygen. (Justice Center Exhibit 9 and Hearing testimony of [redacted], Justice Center Investigator II)

8. The hospital administered oxygen to the Service Recipient via a mask. The mask was intended to be placed over the Service Recipient's mouth and nose, and to be held on the Service Recipient's face with straps attached to the mask that were wrapped around the back of the Service Recipient's head. (Justice Center Exhibit 9 and Hearing testimony of [redacted], Justice Center Investigator II)

9. Because the Service Recipient regularly removed the mask from his head, on [redacted], the hospital requested that the [redacted] send a direct care staff to the hospital to sit with the Service Recipient and hold the oxygen mask over or near the Service Recipient's mouth and nose in order to maintain a satisfactory level of oxygen saturation in the Service Recipient's body. (Justice Center Exhibit 9 and Hearing testimony of [redacted], Justice Center Investigator II)

10. The Subject's normal shift at the IRA was [redacted]. On [redacted], a day that the Subject was not assigned to work, he received a telephone call at home requesting that he work the 11:00 p.m. to 7:00 a.m. shift at the hospital as a sitter for the Service Recipient. He accepted the assignment and, upon his arrival at the Service Recipient's hospital room, the Subject was given an oral report by the preceding shift [redacted] staff sitter who told him how to hold the mask over the Service Recipient's face and about the Service Recipient's resistance to the mask being placed on his face. The Subject also had a conversation with Nurse A (a hospital nurse), in which Nurse A explained to him the importance of maintaining oxygen for the Service Recipient and how to hold the mask near the Service Recipient's face in order maintain his oxygen saturation levels. In the conversation, the Subject agreed to follow Nurse A's instructions. (Justice Center Exhibits 2, 9, and 19: audio recording of Justice Center interrogation of the Subject and interview of Nurse A; and Hearing testimony of the Subject)

11. Throughout the Subject's shift, he repeatedly failed to hold the oxygen mask close enough to the Service Recipient's face to maintain proper oxygen saturation levels. Several times during the shift the Subject was watching television or sleeping. (Justice Center Exhibits 9 and 19: audio recording of Justice Center interview of Nurse A)

12. On several occasions throughout the Subject's shift, Nurse A explained to the Subject the importance of maintaining acceptable levels of oxygen saturation for the Service Recipient. On several occasions, Nurse A demonstrated for the Subject how to hold the mask over the Service Recipient's face, and each time the Subject agreed to do as Nurse A instructed. On one occasion Nurse A found the Service Recipient's oxygen mask tied to the Service Recipient's bed with the mask straps requiring Nurse A to cut the straps in order to get the mask off. On one occasion, Nurse A measured the Service Recipient's oxygen saturation level to be 79 percent, which was well below the normal and satisfactory oxygen saturation level of 95 percent. (Justice

Center Exhibits 9 and 19: audio recording of Justice Center interview of Nurse A)

13. On [redacted] at 9:40 a.m., the Service Recipient was transferred to the hospital's intensive care unit (ICU) after Doctor A (a hospital doctor) examined him and found him to be lethargic and to have oxygen saturation levels between 75 and 79 percent. In the ICU, a continuous positive airway pressure (CPAP) machine was used to administer oxygen to the Service Recipient. The Service Recipient's arms were restrained to prevent him from removing the CPAP mask. The Service Recipient suffered no serious or protracted physical impairment as a result of his low oxygen saturation levels. (Justice Center Exhibit 19: audio recording of Justice Center interview of Doctor A)

14. The OPWDD and New York State Department of Health (DOH) policies do not allow OPWDD direct care staff, such as the Subject, to administer oxygen to service recipients. The OPWDD and DOH policies also provide that hospitals cannot request or require OPWDD direct care staff to administer oxygen to service recipients. (Justice Center Exhibit 17 and Subject Exhibit A)

ISSUES

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

APPLICABLE LAW

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

substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

The neglect of a person in a facility or provider agency is defined by SSL § 488(1) (h), to include:

> "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of neglect shall be categorized into categories pursuant to SSL § 493(4)(c), including Category (3), which is defined as follows:

> Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject 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 through 18) The Justice Center also presented audio recordings of the Justice Center Investigator's interview of witnesses and interrogation of the Subject. (Justice Center Exhibit 19) 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 his own behalf and presented one document. (Subject Exhibit A)

The Justice Center alleges that the Subject failed to provide proper supervision of the Service Recipient by sleeping or by being less than alert while sitting with the Service Recipient at the hospital, and consequently, that he did not ensure that the administration of the Service Recipient's oxygen was maintained. The Subject denies that he was sleeping or was less than alert and contends that, as an OPWDD direct care worker, he lacks the authority to administer oxygen to the Service Recipient. The Subject testified that, regardless of the prohibition against the administration of oxygen by OPWDD direct care workers, he did as he was instructed by Nurse A and held the oxygen mask near the Service Recipient's face for the entirety of his shift, from 11:00 p.m. [redacted] to 7:00 a.m. [redacted]. (Hearing testimony of the Subject)

While the record reflects that the OPWDD and DOH policy prohibits OPWDD direct care

staff from administering oxygen to service recipients, the record also reflects that, although the Subject knew of this prohibition, he nonetheless decided to accept and perform this duty for the Service Recipient for the entirety of his shift. There is no evidence in the record that the Subject objected to the duty, at any time during his shift, based on the OPWDD and DOH policies.

The Subject's claims that he was awake and alert throughout his shift, and that he held the oxygen mask near the Service Recipient's face as he was instructed for the entire shift, are not credible. Not only did Nurse A tell the Justice Center investigator that she found the Subject asleep or otherwise non-attentive to the Service Recipient (Justice Center Exhibit 19: audio recording of Justice Center interview of Nurse A), she also noted the same contemporaneously in the hospital progress notes (Justice Center Exhibit 9), and she also reported the same contemporaneously to the [redacted] Licensed Practical Nurse 2 (LPN2) (Justice Center Exhibits 18 and 19: audio recording of Justice Center interview of [redacted] LPN2). Additionally, the credibility of Nurse A is bolstered by the statement of Nurse B, who stated that she witnessed Nurse A run out of the Service Recipient's hospital room to the nursing desk to retrieve scissors to cut the mask off the Service Recipient's bed, thereby corroborating Nurse A's statement about how the mask was tied to the bed. (Justice Center Exhibit 19: audio recording of Justice Center interview of Nurse B).

The statements of Nurse A, [redacted] LPN2 and Nurse B corroborate each other and are in direct opposition to the Subject's statements and testimony. Additionally, there is no evidence in the record corroborating or otherwise supporting the Subject's contentions. Consequently, the corroborating statements of Nurse A, [redacted] LPN2 and Nurse B are deemed credible evidence, and the Subject's statements and testimony are not credited evidence.

In order to prove neglect, the Justice Center must establish that the Subject breached a custodian's duty that 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 record reflects that the Subject had a duty to properly supervise the Service Recipient by assisting him with his personal needs, advocating for him, and providing companionship for him. (Justice Center Exhibit 17 and Hearing testimony of the Subject) The credible evidence in the record establishes that the Subject breached this duty by sleeping and being less than alert to the needs of the Service Recipient.

Additionally, the credible evidence in the record establishes that although the Subject was not authorized to administer oxygen to the Service Recipient, he nonetheless accepted the assignment of this duty and he breached the duty when he failed to administer oxygen as he was instructed.

Although the record does not establish that the Service Recipient suffered any serious or protracted physical impairment from the Subject's breach of duty, the Subject's conduct resulted in the Service Recipient's oxygen saturation levels being abnormally low and well below acceptable levels, which, given the Service Recipient's diagnosis of pneumonia, was likely to result in physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional 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.

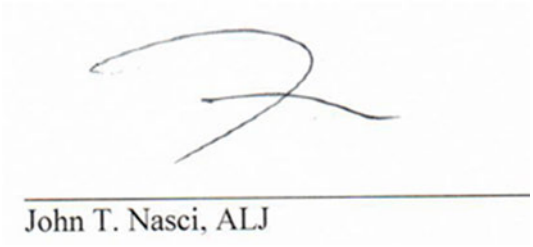
Substantiated Category 3 findings of neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject 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: March 28, 2017
Schenectady, New York



John T. Nasci, ALJ