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: William G. James, Esq.
1283 Middle Road
PO Box 565
Willsboro, New York 12996

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 granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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: April 4, 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: Louis P. Renzi
Administrative Law Judge

Held at: [redacted]
On: [redacted]

Parties: Vulnerable Persons' Central Register
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [redacted], [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], on an outing from the [redacted], House [redacted], located at [redacted], while acting as a custodian, you committed neglect when you allowed a service recipient to eat solid food, in violation of his diet plan, without first receiving approval from a physician.
>
> 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, the [redacted] located at [redacted], is a secure facility for developmentally disabled adults and is operated by the NYS Office for People With Developmental Disabilities

(OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of OPWDD Investigator [redacted]; Justice Center Exhibit 6-B, 7-B)

5. At the time of the alleged neglect, the Subject had been employed by OPWDD for approximately twenty years. The Subject worked as a Nutrition Services Administrator. (Hearing testimony of the Subject)

6. On [redacted], the date of the alleged neglect, the Service Recipient was 32 years of age, and had been a resident of the facility since [redacted] 2010. The Service Recipient is an adult male with diagnoses of mild mental retardation[1], unspecified features of ADHD, bipolar and behavior disorders, antisocial behaviors and fetal drug/alcohol exposure, along with a history of alcohol abuse prior to admission. Untreated lead toxicity at about age two is also suspected. The Service Recipient's relevant symptoms included difficulties in swallowing food with a propensity for choking. Extensive medical testing over time ultimately revealed that the Service Recipient has no physiological abnormality which would interfere with his ability to swallow food. The evidence showed that the Service Recipient has difficulty swallowing and has choked on occasion because he gets distracted, attempts to eat too much at once, eats too quickly and attempts to talk while eating. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Hearing testimony of OPWDD Physician Assistant [redacted]; Justice Center Exhibits 6-B, 9-B, 10-B)

7. On [redacted], the Service Recipient had a facility physician's order in place, with corresponding Dining Guidelines written by the Therapeutic Dining Team to implement the order. Per facility policy, the Therapeutic Dining Team consists of an Occupational Therapist, a

[1] These diagnoses were dated [redacted] and pre-date the language of DSM-V. (Hearing testimony of OPWDD Physicians Assistant [redacted])

Physical Therapist, a Speech Pathologist and a Dietician. (Justice Center Exhibit 18-B) The Subject, a Dietician, was a member of the Service Recipient's Therapeutic Dining Team, which would regularly write and amend his Dining Guidelines as required. (Hearing testimony of the Subject; Hearing testimony of OPWDD Physician Assistant [redacted]; Justice Center Exhibit 19-B)

8. On [redacted], the Dining Guidelines in effect for the Service Recipient stated that food was to be of "ground, moist" consistency before it was served to the Service Recipient. That consistency is defined by OPWDD guidance documents as being processed until it is "moist, cohesive and no larger than a grain of rice." (Justice Center Exhibit 20-B) In this particular case, the Service Recipient's physician's order and corresponding Dining Guidelines calling for ground, moist consistency had expired on [redacted]. Those were not timely renewed due to an oversight. The evidence showed that in such event, the facility physician's opinion was that staff should continue following the expired guidelines until medical staff created a new order, with any changes then being reflected in the Dining Guidelines. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of OPWDD Physician Assistant [redacted]; Justice Center Exhibits 6-B at para.18, 19-B, 20-B)

9. There were multiple amendments to the Service Recipient's Dining Guidelines during the month preceding the incident. On [redacted], the guideline called for his food to be cut into one-inch, bite-sized pieces. (Justice Center Exhibit 20-B) On [redacted], it was revised to ground, moist consistency. (Justice Center Exhibit 19-B) On [redacted], it was amended again to permit serving him "whole food EXCEPT for sandwiches, bread, chips, crackers and cake products cut to ½" pieces." On [redacted] it was amended yet again back to ground, moist consistency, with a "stop date" of [redacted]. The order was given a stop date because the

intent of medical staff was to allow time for the TDT to evaluate the Service Recipient again, and to have the order continued or changed and then added to the order for the following month. Generally, nursing staff would bring expiration dates to the attention of the physician, who would then write a new order. (Hearing testimony of OPWDD Physician Assistant [redacted]) [redacted] was the last substantive revision prior to the incident here (Justice Center Exhibit 11-B), still calling for ground, moist food, after a different incident involving the Service Recipient brought the expired order to staff's attention. (Justice Center Exhibits 6-B, 14-B, 19-B, 20-B) The general and consistent guideline for the Service Recipient was to have his meals served away from other service recipients in order to prevent the Service Recipient from becoming distracted, directly supervised by staff in a quiet and calm environment, with staff directing swallows of liquid alternating with small bites of food and no talking whatsoever by the Service Recipient. (Hearing testimony of the Subject; Justice Center Exhibits 11-B, 14-B, 19-B)

10. Facility policy for formal therapeutic dining evaluations requires that new recommendations by outside medical practitioners are to be reviewed by the facility physician, physician assistant or nurse practitioner. If medical staff agrees with the outside specialist, he or she would then write a consistent order for the Service Recipient. Dietary staff would then revise the Service Recipient's written Dining Guidelines, and thereafter all facility staff would be guided by that document. Orders are also written by medical staff upon recommendations made by the Therapeutic Dining Team (TDT), of which the Subject was a member. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Hearing testimony of OPWDD Physician Assistant [redacted]; Justice Center Exhibits 18-B at paragraphs numbered 11 and 12, 19-B)

11. On [redacted], the Service Recipient was transported to two appointments with

outside medical specialists for testing in connection with his swallowing difficulties. He was transported by the Subject and two other experienced staff members, all of whom had been trained in the Heimlich maneuver. The Subject and one other staff (a speech pathologist) were members of the TDT. The tests included a modified barium swallow and an endoscopy. At the conclusion of the tests, the outside medical staff advised the Service Recipient and the Subject that there was no physiological abnormality indicated, and recommended that the Service Recipient be placed on a "regular" or "whole" diet, meaning that it was no longer necessary to grind or cut up his food. Nevertheless, he would need to continue eating apart from other service recipients in a quiet, calm environment and be directly supervised. The Service Recipient was very pleased and highly motivated by this diagnosis and recommendation. (Hearing testimony of the Subject; Hearing testimony of OPWDD Physician Assistant [redacted])

12. The medical appointments ended at lunchtime. The Service Recipient strongly indicated that he wished to go to McDonald's Restaurant. The Subject acquiesced, and the group stopped to purchase lunch. The Service Recipient ordered two cheeseburgers, French fries and a drink. (Hearing testimony of the Subject; Justice Center Exhibit 22-B)

13. The Subject then directed the group to a nearby park, which was very quiet, calm and private at the time. The Subject did not contact the facility medical staff for authorization to implement the new recommendation allowing the Service Recipient to consume whole food. They sat at a picnic table and ate their lunch. The Subject sat across from the Service Recipient and closely monitored him while he ate the cheeseburgers, but she did not grind or cut them up. (Hearing testimony of the Subject)

14. The Service Recipient successfully consumed his food without incident. After eating, the group returned to the facility. The Subject ended her shift shortly thereafter. (Hearing

testimony of the Subject; Justice Center Exhibits 6-B, 25-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 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 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):

> (h) "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 not 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, along with an audio recording of statements given by the Subject and witnesses. (Justice Center Exhibits 1-B through 25-B) The investigation underlying the substantiated report was initially conducted by OPWDD Treatment Team Leader [redacted], and then assigned to the OPWDD Internal Affairs Unit based in [redacted]. OPWDD

Investigators [redacted] and Lead Investigator [redacted] concluded the investigation. Investigator [redacted] testified for the Justice Center. No other witnesses were called by the Justice Center.

The Subject testified in her own behalf and called OPWDD Physician Assistant [redacted] (PA [redacted]) and OPWDD [redacted] Active Treatment Coordinator [redacted] (ATC [redacted]) as witnesses. The Subject provided no other evidence.

In order to prove neglect, the Justice Center must prove that the Subject was a custodian at the time of the incident, that she owed a duty to the Service Recipient, that she breached that duty, and that such breach 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.

The Justice Center did not prove by a preponderance of the evidence that the Subject committed neglect, as set forth in Allegation 1 of the substantiation letter dated [redacted]. (Justice Center Exhibit 1-B)

Specifically, the evidence proved that on [redacted] the Subject was a custodian as defined in SSL § 488(2), and permitted the Service Recipient to consume cheeseburgers which had not first been processed to a ground, moist consistency without approval from the facility medical staff and without amended Dietary Guidelines. It is concluded that the Subject had a duty and breached it.

Nevertheless, the evidence further proved that the Service Recipient did not suffer any physical injury as a result of the Subject's breach of duty and that, under the circumstances, there was no likelihood of such injury or a serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (Justice Center Exhibit 7-B) Thus, it is concluded that the Subject did not commit neglect as defined in SSL § 488(1)(h).

The Subject acknowledged that she had been employed by the facility for twenty years as a Dietician and then Nutritional Services Administrator. The Subject was therefore a custodian.

The Subject owed a duty to the Service Recipient in her direct care to follow his Dining Guidelines, including any necessary preparation of foods served to him, such as cutting or grinding certain foods, but she breached that duty. Both the Subject and OPWDD Physician Assistant [redacted] (PA [redacted]) testified that the Service Recipient had a known propensity for choking while consuming food, which was ultimately found to be caused by his inattention to eating small amounts, slowly and spaced with sips of a beverage, as well as his constant attempts to speak while eating. The primary focus of the Service Recipient's general Dining Guidelines – eat small amounts, slowly, and away from distraction - was to eliminate the risk of choking. PA [redacted] further testified that a person choking on food could sustain a physical injury, possibly serious. The Service Recipient's guidelines had been modified numerous times in the five weeks prior to the incident here, from whole, uncut foods to "1" bite-size pieces" to ground, moist consistencies. (Justice Center Exhibit 6-B, 11-B, 14-B, 19-B, 20-B) The Subject further testified that she was aware of the general policy addressing dining evaluations and recommendations made by outside consulting practitioners, which was to have a recommended change approved by the facility physician before it is implemented. The Subject admitted that she knew the Service Recipient's Dining Guidelines at the time were for ground, moist food, and she further admitted that she had permitted the Service Recipient to eat unaltered solid food before the change was formally approved by the facility physician. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Hearing testimony of OPWDD Physician Assistant [redacted]; Justice Center Exhibits 18-B at paragraphs 11 and 12, 19-B)

In her defense, the Subject testified that it was not uncommon for recommendations by

outside practitioners to be implemented before returning to the facility. This testimony is supported by the written statement of OPWDD Speech Language Pathologist [redacted], M.A., CCC-SLP, which describes a long-standing protocol for informal dining observations both in the facility and in the community. (Justice Center Exhibit 23-B) The Subject also testified that the service recipients had a right to refuse to accept Dining Guidelines. Indeed, this Service Recipient had a documented history of refusing to cooperate with such guidelines. (Hearing testimony of OPWDD Physician Assistant [redacted]) The Subject further testified that the dining observation of the Service Recipient was done carefully: the cheeseburger lunch took place in a quiet, calm and controlled environment with competent staff present, including two members of the TDT. They closely monitored and prompted the Service Recipient while he was eating, and the Subject testified as to her belief that if any choking incident had actually occurred, she and her staff would have been equipped to handle it. Finally, the Subject testified as to her belief that the lunch would be a good opportunity for an observation of the findings and recommendation of the outside medical staff, who had found no physical abnormality which would cause choking and recommended that they serve whole food to the Service Recipient. The results of the luncheon were completely successful; the Service Recipient consumed his meal as directed and without incident. (Hearing testimony of the Subject; Justice Center Exhibit 6-B) Thus, the evidence supports a conclusion that the actions of the Subject did not result in and were not likely to result in physical, mental or emotional harm to the Service Recipient.

Accordingly, it is determined that although the Subject may have breached her duty as set forth in agency policy, the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject's conduct resulted in or was likely to result in physical injury or the serious or protracted impairment of the physical, mental or emotional condition of the Service

Recipient. Therefore, the Subject has not been shown to have committed the neglect alleged. The substantiated report shall be amended and sealed.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

This decision is recommended by Louis P. Renzi, Administrative Hearings Unit.

DATED: March 30, 2017
Schenectady, New York

Louis P. Renzi, ALJ