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: Jacqueline Seitz, 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], [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: June 12, 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: Keely D. Parr
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
9 Bond Street
Brooklyn, New York 11201
On: [redacted]

Parties: 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
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By: Jacqueline Seitz, 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], [redacted] of neglect by the Subject of a Service Recipient.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Allegation 1

> It was alleged that on [redacted], at the [redacted], located at [redacted][1] [redacted], while a custodian, you committed neglect when you failed to take reasonable steps to resolve an irregularity with a service recipient's anti-seizure medication, following which he missed his evening dose.
>
> 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, located at [redacted], is an Individualized Residential Alternative (IRA) group home for persons with developmental

[1] The facility is located in the [redacted] and not in [redacted], as alleged. Both parties have so stipulated.

disabilities, operated by the Office for People With Developmental Disabilities (OPWDD), a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject was employed by OPWDD as a Developmental Assistant 1 (DA1) and was the assigned Approved Medication Administration Personnel (AMAP). The Subject had received annual trainings in medication administration and pourings, and was AMAP certified. (Hearing Testimony of Subject; Justice Center Exhibits 10 and 11)

6. At the time of the alleged neglect, the Service Recipient was a 28 year-old male with diagnoses of severe intellectual disability and seizure disorder. The Service Recipient received medication for his seizure disorder twice daily. (Justice Center Exhibits 16 and 19)

7. On the day of the alleged neglect, the Subject found an unlabeled bag of pills in the Service Recipient's medication box. The Subject called the DA2, however was told that she was not on duty. The Subject then spoke with the house manager, who informed the Subject that she had no idea what the Subject was talking about. The Subject then gave the unlabeled bag of pills to another staff member to bring to the house manager. The house manager did not know anything about the medication. (Hearing Testimony of Subject; Justice Center Exhibits 10, 14 and 32 – Audio Recording of Subject)

8. The Subject proceeded to pour the Service Recipient's other medications and noticed that one of his medications was missing. The Subject next telephoned the pharmacy but was unable to obtain a refill of the medication because it had recently been refilled. The Subject did not note on the back of the Medication Administration Record Sheet (MARS) that the Service Recipient had missed his 9 p.m. dose of oxcarbazepine, the anti-seizure medication. (Hearing Testimony of Subject; Justice Center Exhibits 10, 14, 19 and 24)

9. The next morning, the Direct Support Assistant (DSA) assigned to AMAP reported to the Subject that she was unable to give the Service Recipient his 7 a.m. dose of the anti-seizure medicine as it was not available. The Subject did not notify the nurse until 8 a.m., when the nurse made rounds. The Service Recipient had already been sent to program that morning, despite the Subject instructing staff not to do so. Once the nurse recognized the pills in the baggy as the anti-seizure medication, she sent a staff to program to administer his medication. The Service Recipient had a seizure at program and was taken to the emergency room, where he was treated and discharged. The staff doctor at the facility, when interviewed by the investigator, stated that the seizure was probably related to the missing doses of anti-seizure medication. (Justice Center Exhibits 10, 24 and 28).

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 abuse and 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) as:

> (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 abuse and/or 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 acts of abuse and/or neglect cited in the substantiated report constitute the category of abuse and 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. Specifically, the evidence establishes that the Subject committed neglect when she failed to take reasonable steps to resolve an irregularity with the Service Recipient's anti-seizure medication, following which he missed his evening dose.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1, 3, 5, 7-14, 16-20, 23-25, 27-29, 32-33) The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted], who was not available to testify at this hearing. OPWDD Investigator [redacted] testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and provided no other evidence.

In order to sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that this breach either 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))

On the day of the alleged neglect, the Subject was employed by OPWDD as a DA1 and was clearly a custodian as that term is defined in Social Services Law § 488(2). As the assigned AMAP, the Subject had a duty to administer the proper medication to the Service Recipient and if unable to do so, to follow established protocols by indicating this on the back of the MARS and by contacting either the nurse on duty or the administrator on duty. (Hearing Testimony of

Investigator; Justice Center Exhibit 10) The Subject breached that duty by failing to indicate that the Service Recipient had missed his 9 p.m. dose of oxcarbazepine, the anti-seizure medication and by failing to notify the nurse on duty and/or the administrator on duty.

The Subject testified that she found an unlabeled bag of pills in the Service Recipient's medication box, that she called the DA2 who informed her that she was not on duty and that she then spoke with the house manager who had no idea what the Subject was talking about. The Subject then had a staff member bring the bag of pills to the house manager, however the house manager did not know anything about the medication. The Subject then telephoned the pharmacy to try to obtain a refill of the medication, however as the medication had been recently refilled, she was unable to do so. (Hearing Testimony of Subject)

The Subject admitted that she did not note on MARS that the Service Recipient had missed his 9 p.m. dose of the anti-seizure medication and that the medication was not available nor contact the administrator on duty. (Hearing Testimony of Subject; Justice Center Exhibit 32 – Audio Recording of Subject) The Subject testified that she was waiting for the house manager to provide her with further instructions. However, the Subject never informed the house manager that the Service Recipient had missed his evening dose of the anti-seizure medication and that the medication was not available.

The Subject did not notify the nurse until the next day, when the nurse made rounds, resulting in the Service Recipient missing his morning dose of the anti-seizure medication. The Subject testified that she informed staff not to send the Service Recipient to program, however no other staff member recalls these instructions and the Service Recipient was sent to program. When the nurse looked at the unlabeled pills in the bag, the nurse immediately recognized the pills as the anti-seizure medicine and sent a staff member to program to administer the dose to the Service

Recipient. Shortly thereafter, the Service Recipient suffered a grand mal seizure and was taken to the emergency room. The staff doctor at the facility, when interviewed by the investigator, stated that the seizure was probably related to the missing doses of anti-seizure medication. (Justice Center Exhibits 10 and 28) Accordingly, the Subject's breach resulted in the serious impairment of the physical, mental and emotional condition of the Service Recipient.

The evidence establishes that the Subject committed neglect when she failed to take reasonable steps to resolve an irregularity with the Service Recipient's anti-seizure medication.

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 of neglect is properly categorized as a Category 3 act. Substantiated Category 3 findings of abuse and/or 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], [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 Keely D. Parr, Administrative Hearings Unit.

DATED: May 31, 2017
Brooklyn, New York