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]

New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Theresa Wells, Esq.

[redacted]

By: Adam B. Conners, Esq.
Fried & Klawon
17 Beresford Court
Williamsville, New York 14221

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 2 act.

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 this report 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: June 28, 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: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People With Special Needs
Administrative Hearings Bureau
[redacted]
On: [redacted]

Parties: New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Theresa Wells, Esq.

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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 or around [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide a service recipient with proper supervision, including ensuring that he received adequate medical care by receiving treatment for his symptoms in a timely manner.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law §493(4)(b).

3. An Administrative Review was conducted and as a result the substantiated report was retained.

4. The [redacted] is located at [redacted], and is operated by [redacted]. The IRA is certified by New York State 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 Quality Assurance Coordinator for [redacted], hereinafter referred to as the QA Coordinator)

5. At the time of the alleged neglect, the Subject had been employed by [redacted] since 2000 as a Registered Nurse (RN) responsible for the medical care and needs of the service recipients. The Subject also provided oversight and supervised direct care staff, including medication administration staff, in regards to the medical care of the service recipients. The Subject worked on weekdays from [redacted] The facility policy required staff to log into the computerized record system, Therap, at least two times per day in order to be updated on a service recipient's care. (Hearing testimonies of the QA Coordinator and the Subject)

6. At the time of the alleged neglect, the Service Recipient was an eighty-one year old male whom had been a long-time facility resident. The Service Recipient communicated by using single words (non-verbal). The Service Recipient was ambulatory, but used a walker for short distances and a wheelchair for longer distances. He attended day program from about 8:00 a.m. until 1:30 p.m. on the weekdays. (Hearing testimonies of the QA Coordinator and the Subject; Justice Center Exhibit 6)

7. The Service Recipient had diagnoses, such as profound intellectual disability, Supraventricular Tachycardia (SVT)-cardiac arrhythmia and paroxysmal atrial fibrillation (loss of heartbeat rhythm)[1], abnormal weight loss, Osteopenia/Osteoporosis, seizure disorder, [redacted], gastro-esophageal reflux disease (GERD) and other medical conditions. At times, he refused to eat and had difficulty eating. He also had no history of bouts of aspiration (act of inhaling fluid into the lungs often after vomiting) and no history of being diagnosed with sleep

[1] Refer to "www.webmd.com"

apnea. (Hearing testimonies of the QA Coordinator and the Subject; Justice Center Exhibits 6, 10, 15 and 28 at page 3)

8. The Service Recipient's (General) Individual Plan of Protective Oversight (IPOP), dated [redacted], and (Residential) IPOP, dated [redacted], required staff to be in hearing range of the Service Recipient during waking hours and conduct periodic bed checks of him once every hour at night. (Hearing testimony of the QA Coordinator; Justice Center Exhibits 6, 9 and 10)

9. On [redacted] and [redacted], the Service Recipient's day program sent to the facility notices indicating that the Service Recipient may have been exposed to an influenza-like virus. On [redacted], the day program's licensed practitioner nurse (LPN) documented that there were no confirmed cases of the flu at the program. (Justice Center Exhibit 6, page 9)

10. On Friday, [redacted], the Service Recipient's day program staff had contacted the IRA two times because they noticed a decline in the Service Recipient's health throughout the week as his coughing and sleeping at program had increased. Facility staff documented the day program concerns by typing a Therap note (T-log) in the facility's computerized record system accessible to staff. The T-log noted the report from the day program staff and that during program the Service Recipient had bouts of "emesis" (bringing up phlegm/vomit). The coughing continued after program on his bus ride back to the facility. (Justice Center Exhibits 6 at page 9 and 29-30)

11. During the night of [redacted], RHA 1 reported that while she sat in a room adjacent to the hallway where the Service Recipient's bedroom was located, she could hear the Service Recipient's snore. RHA 1 further reported that the Service Recipient's snoring was

unusually loud, sounded labored and that the length of time he stopped in between breathes was longer than usual. RHA 1 did not contact the on call nurse, but at 7:16 a.m. on [redacted], she entered a T-log to alert staff about his breathing problem. RHA 1's T-log also noted that the following morning, the Service Recipient had difficulty eating as he gagged on his cereal and brought up a lot of saliva. RHA 1 also noted that the Service Recipient only about one-half of his bowl of cereal and one-half of a piece of toast, but drank his cup of coffee and one-half cup of juice. (Justice Center Exhibits 6, 19 at page 11 and 33 at page 3)

12. On [redacted] and [redacted], the Service Recipient was sent to his day program in spite of his symptoms. It is unclear if the Subject worked on [redacted]. However, the Subject worked her usual shift on [redacted]. (Hearing testimonies of the QA Coordinator and the Subject; Justice Center Exhibit 6)

13. At approximately mid-morning on [redacted], the facility medication administrator called the Service Recipient's medical provider to arrange an appointment date and time. The medical provider offered to schedule an appointment on the same day [redacted] or at three different times on the next day. However, these prompter appointments were declined by the facility and the Service Recipient's appointment was set at 8:15 a.m. on [redacted]. The purpose of the appointment was to address the Service Recipient's stoppage of breath, loud snoring and loss of appetite. (Hearing testimonies of the QA Coordinator and the Subject; Justice Center Exhibits 6, 31 and 37 at page 2)

14. On [redacted] at 4:08 p.m., after her shift ended that day, the Subject remained in the facility and read RHA 1's T-log from the previous morning for the first time. The Subject then had not fully read staff T-logs two times during her shift on that day. At that time, the Subject also discovered that a medical appointment had been scheduled for the Service

Recipient, and at 4:19 p.m., the Subject entered a T-log stating that the Service Recipient's next appointment with his medical provider was set for [redacted] to address his symptoms of stoppage of "breathing for a few seconds," "loud snoring," as well as his eating and drinking difficulties. (Hearing testimonies of the QA Coordinator and the Subject; Justice Center Exhibits 6, 19 at pages 11 and 19)

15. On [redacted], the Subject worked her usual shift. The Service Recipient was transferred again to attend his day program even though he remained ill. The day program's licensed nurse practitioner (LPN) observed that the Service Recipient appeared congested. The LPN called the facility to report her observations and the facility informed the LPN that a medical appointment for the Service Recipient had been scheduled. (Hearing testimonies of QA Coordinator and the Subject; Justice Center Exhibits 6 and 26)

16. At approximately 8:36 a.m. on [redacted], the Service Recipient was assessed by his medical provider. On examination, the Service Recipient appeared to be "ill" with a "very pale" and abnormal pigmentation. In addition, the Service Recipient presented with an "abnormal breath," such that "scattered breath" sounds that were coming from his lungs and abnormal "voice sounds" were heard as he tried to speak. His vital signs, heart rate and rhythm were normal at that time. The medical provider assessed the Service Recipient's condition as possible congestive heart failure with anorexia and edema. The medical provider was concerned that the facility did not appear to recognize the degree of the Service Recipient's illness. (Hearing testimony of QA Coordinator; Justice Center Exhibits 6, 15 and 36)

17. On [redacted], the Service Recipient was immediately transferred to the hospital emergency room, where he was diagnosed with pneumonia consistent with aspiration and admitted into the hospital. The Service Recipient died the following day [redacted] as

the result of a cardiac arrest due to, or as a consequence of, aspiration pneumonia. (Hearing testimony of QA Coordinator; Justice Center Exhibits 6, 8, 15 and 20)

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 abuse and/or 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) 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 abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2, which is defined under SSL § 493(4)(b) 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 at a hearing by a preponderance of the evidence that the Subject(s) 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 abuse and/or 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 1-44) The investigation underlying the

substantiated report was conducted by [redacted] QA Coordinator[2] (the QA Coordinator), who was the only witness who testified at the hearing on behalf of the Justice Center.

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

The Justice Center contends that the Subject failed to provide the Service Recipient proper supervision, including ensuring that he received adequate medical care by receiving treatment for his symptoms in a timely manner.

The Justice relies largely upon the post mortem medical opinion of the Service Recipient's medical provider. The medical provider concluded that, although the Service Recipient's vitals were normal in the days before his hospitalization, the Service Recipient's [redacted] "nocturnal symptoms" (unusually loud snoring and stoppage in between breathes for longer periods), "should have been recognized as abnormal for him, even if he was presumed to have sleep apnea." His medical provider further opined that "[p]oor pulmonary clearance often results in a pneumonia that leads to death" and that the on call RN should have been notified on [redacted]. (Justice Center Exhibit 28 at pages 2-3 and 9) The opinion of the medical provider is credited evidence.

The Subject had a duty to properly supervise and ensure that the Service Recipient received timely and adequate medical care, especially in this case where adverse changes in his health condition occurred which should have been recognized. However, the Subject failed to do so.

In her defense, the Subject argues that when she observed the Service Recipient on [redacted], he had eaten and appeared simply to have a cold. She testified that his vital signs and oxygen levels at that time were normal. The Subject further asserts that, after reviewing the Service Recipient's vital signs, that even the triage nurse at the clinic thought it would be alright

[2] [redacted] was the Quality Assurance (QA) Coordinator of [redacted].

for him to wait to see his medical provider on the [redacted] medical appointment date previously scheduled by the medical liaison on [redacted].

She also argues that the medical liaison had made the [redacted] medical appointment for the Service Recipient to see his medical provider prior to her reading RHA 1's [redacted] T-log (concerning his unusual nocturnal symptoms). Moreover, she claims, the medical liaison told her that the reason the appointment date was delayed was because a facility van was unavailable to transport the Service Recipient.

However, these arguments lack merit. At the time, the Subject never confirmed whether there was a transportation problem. Nor did the Subject assert that she undertook any action whatsoever to obtain a more prompt appointment date for the Service Recipient to visit his medical provider, even though many other dates were offered by the medical provider.

The Subject was aware of the Service Recipient's previous bouts of emesis and coughing while at program on [redacted] as well as his serious pre-existing heart condition, coupled with his advanced age, eating issues and other frailties. She was also aware or should have been aware, after reading RHA 1's [redacted] T-log (after the end of the Subject's shift on [redacted]) reporting that the Service Recipient had unusual nocturnal breathing symptoms, was a factor that was a significant change in his overall health status that required immediate medical attention, despite the fact that he had normal vital sign readings and had eaten some food. The Subject did not fully consider his newly-reported unusual nocturnal symptoms in light of his overall health status. As the facility RN, she was in the best position to assess his need for timely treatment and ensure that he received proper and adequate medical care.

Additionally, the Subject did not follow facility policy requiring her to check the T-logs twice a day. Had the Subject done so, she would have seen RHA 1's T-log earlier in the day,

giving her sufficient time on [redacted] to fully consider the adverse changes in the Service Recipient's symptoms herself and take proper action at that time. Although, the Subject did read the T-log after the end of her shift, she failed to recognize that the Service Recipient's health condition was worsening and that he was very ill. At that time, the Subject was still in the facility and should have directed staff to immediately contact the on call nurse and/or arrange for urgent care of the Service Recipient. At the very least, the Subject could and should have made such arrangements herself the next day [redacted] when she came into work or even arranged to move up his [redacted] scheduled appointment date to visit his medical provider.

Consequently, the Subject's conduct 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 Subject's failure to recognize that the Service Recipient's overall health status was declining and to timely obtain adequate medical care resulted in the continued worsening of his condition that ultimately lead to a diagnosis of aspiration pneumonia, condition which caused his cardiac arrest.

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**.** Category 2 conduct is defined as conduct in which the Subject seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b))

However, based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and the opinion of the medical provider, it is concluded that the Service

Recipient's health, safety and welfare were seriously endangered as a result of the Subject's breach. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or 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 2 finding not elevated to a Category 1 finding shall 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 2 act.

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

DATED: June 21, 2017
West Seneca, New York