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: Thomas C. Parisi, Esq.

[redacted]
By: Samuel N. Iroegbu, Esq.
1531 Central Avenue, Suite 206
Albany, New York 12205

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: February 21, 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: New York State Justice Center for the Protection of People with Special Needs
401 State Street
Schenectady, New York 12305
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
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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:

Offense 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you left a medicine cabinet unlocked and unattended for an unknown period of time, during which time a service recipient was able to obtain two bottles of cough syrup and ingest them, causing illness requiring hospital treatment.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493.

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

4. The facility, located at [redacted], [redacted], is an [redacted] home. The [redacted] housed three service recipients who

were between 20 and 50 years of age. It is operated by [redacted] and is certified by the NYS Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject had been employed by [redacted] for approximately three years. He had been assigned to the [redacted] for approximately two months. The Subject worked as a Direct Care Professional. (Hearing testimony of the Subject)

6. At the time of the alleged neglect, the Service Recipient was 35 years of age, and had been a resident of the facility since [redacted]. The Service Recipient is an adult male with a diagnosis of Prader-Willi Syndrome. As is relevant in this matter, the Service Recipient's diagnosis included mild intellectual disability, but the most significant manifestation of Prader-Willi Syndrome is an insatiable appetite with an uncontrollable urge to ingest food without limit. The [redacted] was specialized for the care of such individuals, and the kitchen and the medication storage cabinet were required to be locked at all times when not in use. The Service Recipient was permitted to be out of visual supervision while inside the [redacted], but his Residential Habitation Plan and Individual Plan of Protection required constant visual supervision outside the home and in the community. (Hearing testimony of [redacted] Quality Assurance Director [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 9, 20, 25, 26)

7. The Service Recipient, unobserved by staff, obtained and consumed two 4-ounce bottles of diabetic sugar free cough syrup on [redacted], between 3:30 and 4:30 p.m. At approximately 5:15 p.m., the Service Recipient became lethargic, disoriented and unable to stand. The Service Recipient was transported to the hospital for diagnosis and treatment. He remained hospitalized for two days. The cough syrup contained dextromethorphan hydrobromide, which

presented the potential for a strong negative interaction, such as hallucinations, with another medication being administered to the Service Recipient. (Hearing testimony of [redacted] Quality Assurance Director [redacted]; Justice Center Exhibits 9, 20, 21)

8. The cough syrup was stored in the medication cabinet, located in the living room of the facility. At the time of the alleged neglect, the Subject was assigned as the facility medication administrator, and had possession of the key to the cabinet. It was his duty to access, administer and secure all medications during his shift. (Hearing testimony of the Subject; Hearing testimony of [redacted] Quality Assurance Director [redacted]; Justice Center Exhibit 9)

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 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:

> (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 neglect shall be categorized into categories pursuant to SSL § 493(4), including Category (2), which is defined as follows:

> (b) 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 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 "Offense 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents, along with physical evidence, obtained during the investigation. (Justice Center Exhibits 1-28 A & B) The investigation underlying the substantiated report was conducted by [redacted] Director of Quality Assurance [redacted] who testified at the hearing on behalf of the Justice Center.

The Subject testified in his own behalf and also called [redacted] Residence Supervisor [redacted] as a witness. The Subject provided no other evidence.[1]

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 he breached that duty, and that his 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))

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect when he breached his duty to keep the [redacted] medication storage cabinet locked and/or under direct observation for a period of time during and after administering medications to the residents of the [redacted]. He further breached his duty to supervise the Service Recipient during the same time

[1] The hearing lasted three days, spread over an eight-month period. The Subject was absent on the last day, [redacted], due to international travel. On [redacted], he provided a signed authorization for his attorney to conduct all remaining proceedings in his absence. The document was accepted and marked "ALJ-1" for identification.

period, which permitted the Service Recipient to obtain and ingest two bottles of diabetic cough syrup. As a result, the Service Recipient became ill and was hospitalized. .

Specifically, the preponderance of the evidence established that at the time of the alleged neglect, [redacted] at the [redacted], the Subject was a custodian as that term is defined in SSL § 488(2). He testified that he was a Direct Care Professional and was on duty at the time. He, along with other staff, was responsible for supervising the three service recipients residing in the [redacted]. (Hearing testimony of the Subject; Hearing testimony of [redacted] Residence Supervisor [redacted]).

The evidence showed that Subject was the assigned medication administrator during the afternoon shift on [redacted] at the [redacted], and was the only staff member in control of the medication cabinet at that time. He testified that he kept the key in his pocket. The Subject reported for his shift at approximately 2:45 p.m. on that day. He began administering medications to the service recipients in the [redacted] at approximately 3:30 p.m. (Hearing testimony of the Subject; Justice Center Exhibit 9)

The evidence further proved that the Service Recipient became lethargic while at the supper table. He then became disoriented and unable to stand. (Hearing testimony of [redacted] Residence Supervisor [redacted]) Staff called the agency nurse and then 911. The Service Recipient was transported to the hospital, where he remained for two days. The medical evidence proved that the Service Recipient's symptoms were determined to have been caused by an overdose of the cough syrup. (Hearing testimony of [redacted] Director of Quality Assurance [redacted]; Hearing testimony of [redacted] Residence Supervisor [redacted]; Justice Center Exhibits 9, 20)

At the hospital, the Service Recipient gave a statement to staff and his parents. He admitted he had taken the medications from the unlocked and unattended medicine cabinet and ingested

them. (Hearing testimony of Residence Supervisor [redacted]) The Service Recipient gave additional statements to Director [redacted]. (Justice Center Exhibit 9) The Service Recipient was consistent in his reports of what he had done, and that the Subject was the staff who had been on duty at the time. (Hearing testimony of [redacted] Director of Quality Assurance [redacted]; Hearing testimony of [redacted] Residence Supervisor [redacted]; Justice Center Exhibits 9, 11, 12)

The medical evidence further proved that the initial symptoms of such overdose would be expected to appear within 30 to 90 minutes after ingestion, based upon the chemical content of the cough syrup, and considering the diagnosis of the Service Recipient. It is thus concluded that the cough syrup was more likely than not ingested between 3:30 p.m. and 4:30 p.m. (Hearing testimony of [redacted] Director of Quality Assurance [redacted]; Justice Center Exhibits 9, 20, 21)

In his defense, the Subject claimed that the Service Recipient had been left alone for a period of time in the [redacted] prior to the Subject arriving to begin his shift, and the Service Recipient could have taken the cough syrup before the Subject came on duty. (Hearing testimony of the Subject; Justice Center Exhibit 2)

The Subject's position is controverted by the testimony and written statements of [redacted] Residence Supervisor [redacted]. She testified that at the time in question, she arrived at the [redacted] and found the Service Recipient in the [redacted] with Day Program Staff Member [redacted], who stayed with the Service Recipient when they arrived at the [redacted] and found it empty. (Hearing testimony of [redacted] Residence Supervisor [redacted]; Justice Center Exhibits 9, 11, 12)

The Subject further claimed that he found the medication cabinet unlocked upon arrival for his shift, but the evidence showed that he had failed to notify his supervisor or anyone else. Residence Supervisor [redacted] testified that should such an event occur, immediate notification to a

supervisor would be extremely important, particularly in this [redacted] where staff were trained to care for service recipients afflicted with Prader-Willi Syndrome. (Hearing testimony of [redacted] Director of Quality Assurance [redacted]; Hearing testimony of [redacted] Residence Supervisor [redacted]) It is thus concluded that the claims of the Subject in this regard are not credited evidence.

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.

The Subject's conduct seriously endangered the health, safety or welfare of the Service Recipient. The Subject neglected to secure the medication cabinet or properly supervise the Service Recipient, thereby allowing him to access and ingest cough syrup and become ill. Accordingly, it is determined that the substantiated report is properly categorized as a Category 2 act.

Category 2 conduct shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that such custodian engaged in Category 2 conduct. 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 Louis P. Renzi, Administrative Hearings Unit.

DATED: February 6, 2017
Schenectady, New York

Louis P. Renzi, ALJ