**STATE OF NEW YORK**
**JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS**

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| In the Matter of the Appeal of<br><br>[redacted]<br><br>Pursuant to § 494 of the Social Services Law | **FINAL DETERMINATION AND ORDER AFTER HEARING**<br><br>**Adjud. Case #:**<br>[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 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**: April 6, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

**STATE OF NEW YORK**
**JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS**

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In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED DECISION AFTER HEARING**

**Adjud. Case #:** [redacted]

Before: Louis P. Renzi
Administrative Law Judge

Held at: [redacted]
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:

**Allegation 1**

> It was alleged that on [redacted], at the [redacted] – Unit [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to properly train staff on a service recipient's food consistency requirements, as a result of which the service recipient choked.
>
> 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 in [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 Exhibits 6-A, 7-A)

5. At the time of the alleged neglect, the Subject had been employed by OPWDD for approximately twenty years. The Subject is a Registered Dietician and worked as a Nutrition Services Administrator I. She had previously served as a Dietician during her tenure at the facility. (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 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 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 had difficulty swallowing and had choked on occasion because he becomes 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's Assistant [redacted]; Justice Center Exhibits 6-A, 13-A, 14-A)

7. On [redacted], OPWDD issued OPWDD Choking Prevention Initiative – Preparation Guidelines for Food and Liquid Consistency (the guidance document) which was in effect at the time of the alleged neglect here. In relevant part, the guidance document defines ground food as food which is processed until it is "…moist, cohesive and no larger than a grain

[1] These diagnoses were dated [redacted] and pre-date the language of DSM-V.

of rice (in relish like pieces, similar to pickle relish)." In the case of dry cereal, the guidance document instructs that it should be "…ground in a food processor or crushed in a baggie into smaller-sized pieces. The cereal MUST be moistened with milk and allowed to absorb the milk before serving." On [redacted], the existing Dining Guidelines for the Service Recipient, revised on [redacted], stated that food was to be of "moist ground" consistency before it was served to the Service Recipient. (Hearing testimony of OPWDD Investigator [redacted]; Justice Center Exhibits 6-A, 10-A, 16-A, 17-A)

8. During the period [redacted] through [redacted], the Subject received OPWDD training in "Food Consistency Guidelines" and "Choking Prevention Initiative" with respect to the new guidance document. During the period [redacted] through [redacted], the Subject conducted formal training of direct care staff in the same subject matter. In addition, per facility policy number [redacted], Therapeutic Dining Evaluation, revised [redacted] (Justice Center Exhibit 18-B), the Therapeutic Dining Team consists of an Occupational Therapist, a Physical Therapist, a Speech Pathologist and a Dietician. The Subject, a Dietician, was a member of the Service Recipient's Therapeutic Dining Team. The team would regularly write and amend the Service Recipient's Dining Guidelines as required. When changes were ordered in any service recipient's food consistency requirements, the evidence showed that it was customary for the Subject to participate in training staff on the updated guidelines for that specific service recipient. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6-A, 17-A, 22-A, 23-A)

9. On [redacted], the Service Recipient had a choking incident at the facility; direct care staff had served him Cheerios cereal which had been soaked in milk, but had not been ground. The Heimlich maneuver was performed, and he expelled a single Cheerio and a small

amount of milk. He experienced emotional upset as a result of the incident, documented by medical staff. Following the issuance of the [redacted] guidance document, direct care staff had been trained by the Subject that grinding or crushing the cereal beforehand was not necessary because the milk softened the cereal significantly. Prior to the issuance of the guidance document, facility procedure required only soaking the cereal in milk for a period of time before serving. The Subject misunderstood the new guidance document, and had omitted the grinding requirement for dry cereal when she had trained staff. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6-A, 13-A, 16-A, 23-A)

10. On [redacted], the Service Recipient had a facility physician's order in place, with Dining Guidelines written by the Therapeutic Dining Team to implement the order. (Hearing testimony of OPWDD Physician's Assistant [redacted]; Justice Center Exhibits 10-A, 12-A, 15-A) There had been multiple amendments to the Service Recipient's Dining Guidelines during the month of [redacted] immediately preceding the incident. The stated general guideline for the Service Recipient was to have his meals served away from other service recipients, 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. On [redacted], the guideline called for his food to be cut into one-inch, bite-sized pieces. On [redacted], it was revised to "moist ground" consistency. 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], the Physician's Orders were amended yet again to downgrade back to "moist, ground" consistency, with a "stop date" of [redacted]. The Dining Guidelines were revised on [redacted] to reflect that order.

(Justice Center Exhibits 15-A, 17-A) In the absence of a new Physician's Order, the current protocol was to continue observing the guidelines of the expired order. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Hearing testimony of OPWDD Physician's Assistant [redacted]; Justice Center Exhibits 15-A, 17-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 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):

> (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 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. (Justice Center Exhibits 1-A through 23-A) 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 on behalf of the Justice Center. No other witnesses were called by the Justice Center.

The Subject testified in her own behalf and called OPWDD Physicians 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, 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 proved 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-A)

Specifically, the evidence proved that on the date of the incident, [redacted], the Subject was a custodian as defined in SSL § 488(2). The Subject was required to train staff regarding food preparation with a goal of attaining necessary consistencies, and had an ongoing duty to correctly determine the technical requirements of OPWDD policies and guidance documents before training others. The Service Recipient required a ground, moist diet at the time of the incident. Prior to the date of the incident, the facility adopted a new OPWDD guidance document for preparing certain foods. The Subject incorrectly determined and trained

staff on one of the then-new requirements for preparing dry cereal. On [redacted], when staff utilized the incorrect procedure as trained, the Service Recipient had a choking incident.

On [redacted], OPWDD issued a guidance document entitled OPWDD Choking Prevention Initiative – Preparation Guidelines for Food and Liquid Consistency. (Justice Center Exhibit 16-A) This document sets forth the specifications for preparing foods to certain consistencies, as may be required by the facility Dining Guidelines for individual service recipients. On [redacted], the effective Service Recipient's Dining Guidelines required that he must be served food with a ground, moist consistency, which was defined by the guidance document as being processed until it is "…moist, cohesive and no larger than a grain of rice". In the case of dry cereal, which is the situation presented here, the document calls for it to be "…ground in a food processor or crushed in a baggie into smaller-sized pieces. The cereal MUST be moistened with milk and allowed to absorb the milk before serving." (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6-A, 10-A, 16-A)

The Subject admitted that she, along with others, had misunderstood the specific directions in the guidance document for grinding or crushing dry cereal prior to moistening with milk. In or about [redacted] through [redacted], the Subject had incorrectly trained and advised direct care staff that dry cereal (except for those which would not soften in milk) needed only to be well-moistened with milk prior to serving, which was the facility procedure prior to the issuance of the guidance document. That misunderstanding continued without being recognized or corrected until the time of the incident. (Hearing testimony of the Subject; Justice Center Exhibits 2-A, 6-A, 17-A, 23-A)

The evidence proved that on [redacted] direct care staff relied upon such training and

prepared the Service Recipient's cereal incorrectly. He then had a choking incident while consuming the cereal. Although there was no resulting physical injury, the Service Recipient was described as being "anxious and agitated" by the incident as reported by the responding physician. (Justice Center Exhibit 13-A) The hearing record contains some evidence that there may have been other factors which caused the Service Recipient's choking incident, such as a sore or inflamed throat from an upper endoscopy undergone earlier in the day, and the suggestion by the Subject that the Service Recipient had actually choked on the liquid milk rather than the cereal itself, either or both of which are possible, but the proximity in time between the error in preparing his food and the choking incident is inescapable. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of the Subject; Hearing testimony of OPWDD Physicians Assistant [redacted]; Justice Center Exhibits 6-A, 11-A, 12-A, 13-A, 22-A)

Generally, service recipients in the facility have specified procedures for eating meals and snacks. These procedures are referred to as Dining Guidelines, which can be amended from time to time pursuant to changes in the service recipient's medical orders as the needs of the service recipient change. The guidelines are written by the Therapeutic Dining Team assigned to the individual service recipient, upon receipt of an order from medical staff. The Subject was a member of the team assigned to the Service Recipient here, and was also responsible for ongoing training of direct care staff whenever changes were made to his Dining Guidelines. The Subject was, in part, responsible for the Service Recipient's Dining Guidelines which were utilized by staff in preparing and serving food to him, such as cutting or grinding certain foods beforehand. The evidence therefore supports a conclusion that the Subject owed a continuous duty to the Service Recipient, up to and including the time of the incident here.

In her defense, the Subject testified that for many years, it had been customary to serve unground Cheerios well-soaked with milk to service recipients needing a ground, moist diet, including the Service Recipient, and this had been done without incident. The Subject further testified that the OPWDD guidance document requirements as to a ground, moist diet (Justice Center Exhibit 16-A) were inconsistent and confusing for several reasons, and that even her OPWDD superiors in the field differed on what was actually required as to certain foods. (Hearing testimony of the Subject; Justice Center Exhibit 2-A)

Nevertheless, while the Subject's testimony was credible, her arguments are not compelling. First, the specific instructions in the guidance document as to dry cereal are not unclear, despite the fact that they may have created a change in the facility's long-standing procedure. (Justice Center Exhibit 16-A at page 3) Second, the Subject's concerns about the guidance document would certainly have been valid for someone in her position, but the document had been issued in [redacted], more than two years before the incident complained of here and approximately two months prior to the first formal trainings conducted by the Subject. There was sufficient time for her to have obtained additional and satisfactory guidance from her superiors before training direct care staff. Therefore, the record does not support a conclusion that the Subject's unresolved confusion can excuse her failure to clarify food preparation requirements before training other staff.

The probability of the Service Recipient choking on his food from time to time was well known to the Subject and staff, evidenced by the great amount of medical and dietary staff attention given to his Dining Guidelines in the time leading up to this incident. (Hearing testimony of the Subject; Hearing testimony of OPWDD Physicians Assistant [redacted]) The record therefore supports the further conclusion that the Subject's failure to

properly train staff regarding the procedure set out in the OPWDD guidance document was likely to result in a physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, in violation of SSL § 488(1)(h).

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.

A substantiated Category 3 finding 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 Louis P. Renzi, Administrative Hearings Unit.

**DATED**: April 3, 2017
Schenectady, New York

Louis P. Renzi, ALJ