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: Juliane O'Brien, Esq.

[redacted]
By: Charles S. DeAngelo, Esq.
Fessenden, Laumer & DeAngelo, PLLC
81 Forest Avenue, P.O. Box 0590
Jamestown, New York 14702-0590

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 7, 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
1200 East and West Road
West Seneca, New York 14224
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] 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], while acting as a custodian, you committed neglect when you failed to provide a service recipient with proper supervision, during which time she accessed and/or drank orange juice despite being prohibited from ingesting food and drink orally.
>
> 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 a State Operated Individualized Residential Alternative [redacted] for disabled persons that is operated by the New York State Office for People With Developmental Disabilities (OPWDD).

[redacted] is a facility that is subject to the jurisdiction of the Justice Center. At the time of the alleged neglect, there were eleven service recipients that resided at the facility, most of whom attended a day habilitation program. Staff who worked at the facility were employees of the [redacted].[1] (Hearing testimony of OPWDD Investigator [redacted]; Justice Center Exhibits 6 and 8)

5. [redacted] policy required that staff administering medications must remain with the service recipient "until the procedure is completed" and that, after medications are administered to each service recipient, staff were required to sign their initials on that particular service recipient's Medication Administration Record (MAR) and document the administration in the residential notes. Staff were allowed to be assigned to handle other duties after completing medication administration duties. (Hearing testimony of OPWDD Investigator [redacted] and Justice Center Exhibit 39)

6. At the time of the alleged neglect, the Subject was employed by the [redacted] as a Licensed Practical Nurse (LPN) and had worked at the [redacted] since [redacted] of 2014. The Subject was familiar with the Service Recipient's Behavioral Support Plan (BSP) and Plan of Protective Oversight (POPO). On [redacted], the Subject worked the day shift from [redacted] On that day, the Subject had been assigned as the medication administration nurse under the supervision of the morning Senior License Practical Nurse (SLPN), hereinafter referred to as SLPN 1. At that time, the Subject was required to be under the supervision of a SLPN whenever she worked. SLPN 1 was also assigned to provide range of scan supervision to the Service Recipient. The Subject was a custodian as that term is so defined in

[1] The [redacted] administers and oversees State operations for OPWDD locally, including the direct delivery of services and supports to people with developmental disabilities by State staff.

SSL § 488(2). (Hearing testimonies of the Subject and OPWDD Investigator [redacted], Justice Center Exhibits 6, 8, 36-38; and Justice Center Exhibit 43: audio CD containing the interrogation of the Subject and interview of SLPN 1)

7. On the day of the incident, the Subject worked along with five other staff persons, which consisted of one SLPN, four LPNs and one Direct Support Aid in Training (DSAT). At 11:00 that morning, one of the LPNs left the facility before her shift ended due to a family emergency and the DSAT's shift had ended at 12:00 noon. (Hearing testimony of OPWDD Investigator [redacted]; Justice Center Exhibits 6 and 8-9)

8. At the time of the alleged neglect, the Service Recipient was an ambulatory non-verbal forty-nine year old female who had been a resident of the facility for approximately one year. She communicated by pushing staff toward what she needed. The Service Recipient's diagnoses included bipolar disorder, autism, obsessive compulsive disorder and other medical conditions. The Service Recipient was receiving her nutrition and hydration through a gastronomy tube (g-tube) and was restricted from drinking fluids by mouth (or NOP status) due to a risk of aspiration and difficulty swallowing. (Justice Center Exhibits 8, 12 and 36-38)

9. According to the Service Recipient's revised BSP dated [redacted] and revised POPO dated [redacted] and [redacted] addendum, staff were required to maintain a range of scan level of supervision with close proximity to the Service Recipient. All of the Service Recipient's plans noted her known history of seeking and attempting to consume beverages as a targeted behavior. (Justice Center Exhibits 37-38)

10. Sometime between 10:30 a.m. and 11:00 a.m. on [redacted], SLPN 1 told the Subject that she and the afternoon SLPN, SLPN 2, would be the only staff at the facility able to supervise the service recipients that afternoon. Sometime between 11:30 a.m. and 11:45 a.m.

that day, SLPN 1 told the Subject further that, after she completed medication administration, the Subject was to assist with the Service Recipient's supervision before and after SLPN 2's arrival at 12:00 noon. After hearing SLPN 1's oral direction, the Subject confirmed that she understood. No other staff heard SLPN 1 give the oral directive to the Subject in regards to the supervision of the Service Recipient. There was no written documentation of SLPN 1's oral directive transferring supervision of the Service Recipient to the Subject. (Justice Center Exhibits 8 and 9-10; Justice Center Exhibit 43: audio CD containing the interrogation of the Subject and interview of SLPN 1)

11. Shortly before 12:00 noon, the DSAT brought the Service Recipient into the facility office, where the Subject, SLPN 1 and another LPN were working, then concluded his shift. SLPN 1 was talking on the telephone and awaiting the arrival of SLPN 2 to whom she would transfer responsibility of supervision of the Subject and the Service Recipient for the afternoon. SLPN 1 was prohibited from leaving the facility until SLPN 2 came into the office at 12:00 noon. There were three or four other service recipients present in the facility at that time. (Hearing testimony of the Subject, Justice Center Exhibit 8; Justice Center Exhibit 43: audio CD of the interrogation of the Subject and interview of SLPN 1)

12. At about 12:00 noon, the Service Recipient was sitting in an office chair near SLPN 1's desk and in front of a medicine cart on which was an opened bottle of orange juice that was left over from a prior shift. The Subject and another LPN were sitting in the office at the desk completing documentation with their backs to the Service Recipient. (Hearing testimony of the Subject; Justice Center Exhibits 6, 9, 11-12 and 14)

13. At 12:00 noon, as SLPN 2 entered the office and was hanging up her coat, she observed the Service Recipient drinking out of the orange juice bottle. SLPN 1 was still on the telephone by her desk. SLPN 2 yelled out and alerted staff. A staff member immediately took the

orange juice bottle from the Service Recipient. SLPN 1 instructed the Subject to contact the on-call nurse. The nurse came, performed an assessment and found no negative impact upon the Service Recipient as a result of the incident. As a safety measure, the nurse directed staff to observe the Service Recipient and check her vitals every four hours for a twenty-four hour period. During the twenty-four hour period, the Service Recipient did not exhibit any ill effects from the incident. (Justice Center Exhibits 8-9, 11-12 and 14)

14. At the time of the incident, it was common practice for facility supervisors to issue oral directives in order to change staff supervisory duties for service recipients with range of scan supervision levels. Subsequent to the incident, a change of policy was instituted requiring all transfers of supervision to be confirmed in writing. Additionally, the Service Recipient was no longer allowed to be in the office. (Hearing testimonies of OPWDD Investigator [redacted] and the Subject; and Justice Center Exhibit 10)

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 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) 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 3, which is defined under SSL § 493(4)(c) as follows:

> 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(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 abuse and/or 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. (Justice Center Exhibits 1-42 and Justice Center Exhibit 43: audio CD of interrogations and interviews) The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted], 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 Subject Exhibit A which was admitted into evidence.

The narrow issue in this case is whether the Subject had a duty to provide range of scan supervision to the Service Recipient at the time the Service Recipient drank from the orange juice bottle.

The evidence establishes that at the time of the incident, SLPN 1 had not effectuated a valid transfer of the Service Recipient's supervision to the Subject. The evidence also establishes that, under SLPN 1's oral directive, the Subject's completion of her medication administrator duties was a condition precedent to the Subject's obligation to supervise the Service Recipient. Since the Subject had not yet completed her medication administrator duties at the time of the incident, the obligation to supervise the Service Recipient under SLPN 1's oral instructions had not been

triggered. (Justice Center Exhibit 6)

SLPN 1's version of her oral directives to the Subject (as reported to the investigator during her [redacted] interrogation and reiterated in her two written statements dated [redacted]), was inconsistent with the Subject's account and understanding. (Justice Center Exhibits 9-10 and 43) However, the record reflects that there was no corroboration of the conversation between SLPN 1 and the Subject by independent witnesses or documentary evidence. Additionally, the Subject's understanding of SLPN 1's oral instructions (that after the Subject finished her job, she was to assist with the Service Recipient's supervision if necessary before and after SLPN 2 arrived), reasonably implies that the Subject's duty to supervise the Service Recipient would only arise when SLPN 1 needed help with the Service Recipient's supervision. However, at the time of the incident, SLPN 1 was still present in the office and on the telephone, the Subject had not yet completed her medication administration and SLPN 1 had not requested that the Subject assist with the Service Recipient's supervision.

The Subject's hearing testimony was credible and her arguments were persuasive. Additionally, the Subject's testimony was consistent with her statements to the investigator and the investigator's hearing testimony corroborated the Subject's claim that she had not yet completed administering medication to the service recipients.

Because the credible evidence in the record establishes that, at the time of the incident, the Subject had not yet completed her duties as medication administrator, the Subject was under no duty to supervise the Service Recipient. Consequently, the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will 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 Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: March 31, 2017
West Seneca, New York

Mary Jo Lattimore-Young,
Administrative Law Judge