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]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision in its entirety is hereby adopted by the Executive Director.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

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: July 31, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Lourdes Martinez, Esq.

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: Sharon Golish Blum
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
125 East Bethpage Road, Suite 104
Plainview, New York 11803
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: Kristin Kopach, Esq.

[redacted]
By: Lourdes Martinez, Esq.
Garfunkel Wild, PC.
111 Great Neck Road, 6th Floor
Great Neck, New York 11021

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 report of substantiated finding dated [redacted] of neglect by the Subject of a Service Recipient.

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

Allegation 1

It was alleged that between [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to properly follow-up with the pharmacy for and or ensure timely procurement of necessary medication for a service recipient.

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 at [redacted] is a residence for male adults with developmental disabilities that is operated by [redacted], which is certified by the New York State Office for People With Developmental Disabilities (OPWDD) and, as a result, is a provider agency that is subject to the

jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject, who had graduated from Nursing School in [redacted], had been employed as the facility Registered Nurse (RN) for five weeks. The Subject received general facility training on [redacted] and onsite nursing specific training from [redacted] Director of Nursing on [redacted] and [redacted]. A term of the Subject's employment was that he was to work fourteen hours weekly, the days and times of which were flexible and at his discretion. As the facility RN, the Subject was the only medical professional assigned to be at the facility on a regular basis. (Hearing testimony of the Subject) The Subject's responsibilities included maintaining and updating health records, supervising the Approved Medication Administration Personnel's (AMAPs) administration of medications and ensuring all medications were available and stored appropriately. (Subject Exhibit D) The Subject was a custodian as that term is so defined in Social Services Law § 488 (2)

6. At the time of the alleged neglect, the Service Recipient was a thirty-five year old facility resident whose diagnoses included moderate intellectual disability and autism. The Service Recipient had a history of seizures and, prior to [redacted], was prescribed 50 mg of Lamictal three times daily to prevent seizures. (Justice Center Exhibit 15)

7. On [redacted], the Service Recipient was taken by a Facility Direct Support Professional (DSP) 1, an AMAP, to an appointment with his neurologist, who changed the Service Recipient's anti-seizure medication. Under the new regimen, from [redacted] until [redacted], the Service Recipient was to receive 100 mg of Lamictal twice daily, and from [redacted] and thereafter, the Service Recipient was to receive 250 mg of Extended Release Lamictal once daily. (Justice Center Exhibits 8, 10 and 13)

8. On [redacted], DSP 1 faxed the Service Recipient's two new prescriptions to

the pharmacy utilized by the facility and she thereafter received a telephone call from the pharmacist advising her that the pharmacy would forward the first prescribed medication to the facility, but that the second prescribed medication required prior approval before the prescription could be dispensed. (Justice Center Exhibit 13)

9. On [redacted], DSP 1 advised the Subject of the change in the Service Recipient's medication regimen, that the second prescription of the Extended Release Lamictal required prior approval and that the pharmacist told her that once the pharmacy received the prior approval, it would dispense the second medication. (Hearing testimony of the Subject and Justice Center Exhibit 13)

10. On an unspecified date following their first conversation about the Extended Release Lamictal, DSP 1 spoke to the Subject again and reiterated that the medication would not be dispensed by the pharmacy until it received prior authorization. (Hearing testimony of the Subject)

11. Between [redacted] and [redacted] the Subject did not follow up with the pharmacy to ascertain the status of the Extended Release Lamictal. As of [redacted], the date that the Service Recipient was to begin taking Extended Release Lamictal, the medication had not been dispensed by the pharmacy. (Hearing testimony of the Subject and Justice Center Exhibits 7 and 14)

12. On [redacted], the Service Recipient received his nighttime dose of 100 mg of Lamictal. However, after that evening dose the Service Recipient received no anti-seizure medication at all until [redacted]. (Hearing testimony of [redacted] Chief Operations Officer [redacted] and Justice Center Exhibit 12)

13. On [redacted], the Service Recipient suffered a seizure and was transported to

a local hospital emergency department, where he was treated with anti-seizure medication and discharged that day. (Justice Center Exhibits 7, 9 and 14)

14. Because the pharmacy continued to require prior authorization to dispense the Service Recipient's [redacted] prescription of the Extended Release Lamictal, it was not until [redacted], that the approval was obtained and the medication was dispensed and given to the Service Recipient. (Hearing testimony of [redacted] Chief Operations Officer [redacted] and Justice Center Exhibits 11 and 12)

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 allegation constitutes 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 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 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…

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 of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act constitutes 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 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 act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or 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 the act described as Allegation 1 in the Report of Substantiated Finding.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-15) The investigation underlying the substantiated report was conducted by [redacted] former Director Of Training [redacted]; however, [redacted] Chief Operations Officer [redacted] testified at the hearing on behalf of the Justice Center.

The Subject testified at the hearing in his own behalf and provided four documents as

evidence. (Subject Exhibits A-D)

A finding of neglect requires that a preponderance of the evidence establishes that the Subject engaged in conduct that breached his duty to the Service Recipient and that the breach of duty 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))

Most of the facts of this case are not in dispute. The Subject signed [redacted] Employment Agreement (Subject Exhibit D), which states that the Subject was responsible for maintaining health records, supervising AMAP's administration of medications and ensuring all medications were available. On [redacted], the Subject signed his acknowledgment on the Clinic Visit Summary Form (Justice Center Exhibit 8) that he had reviewed the Service Recipient's new medication regimen. The Subject testified that he was the one who wrote in the entry for the Service Recipient's second prescription of 250 mg of Extended Release Lamictal on the Service Recipient's Medication Chart (Justice Center Exhibit 12, page 4).

The Subject testified that, aside from a general facility orientation training, he had received two days of specific facility RN training from [redacted] Director of Nursing in the facility, which included being shown the service recipients' medical records, reviewing their medications and reviewing the process of ordering medication from the specific pharmacy from which all facility service recipients' prescriptions were dispensed. The Subject testified that he knew that he was the only RN assigned to the facility and that, if he was in doubt as to any matter, he could have telephoned the [redacted] Director of Nursing at any time. The Subject testified that he had not been trained with respect to medication authorization issues and that, even as of the date of his hearing testimony, he was unsure as to the nature of authorization requirements and how they were resolved.

The Subject testified that he had been advised on two occasions by DSP 1 before the Service Recipient's [redacted] seizure, that the pharmacy required prior authorization to dispense the Service Recipient's prescription for the Extended Release Lamictal and that because DSP 1 told him that she would follow-up with the pharmacy, he assumed that DSP 1 would resolve the problem. The Subject testified that when he was interrogated over the telephone by [redacted] former Director of Training [redacted] on [redacted] (Justice Center Exhibit 6, page 4), he was nervous and, although he stated at that time that he took responsibility for the incident and that it had been his fault, upon further reflection, he felt that the incident occurred as a result of missed communications and that he was not at fault.

The Subject's testimony, that he was not responsible for faxing prescriptions to the pharmacy and that he was not familiar with the prior authorization requirements, is accepted as credible. However, the issue in this case is whether the Subject's duty, as the facility RN, to ensure that medications were available, would have included familiarizing himself with and resolving the pharmacy's requirement for prior authorization to dispense the Service Recipient's prescription for the Extended Release Lamictal, in time for the Service Recipient to receive the medication, as prescribed, on [redacted].

The Subject's counsel argued that the Subject was young and new to the job, that he had been inadequately trained and was not shadowed for any period of time after his hiring, that he was not principally responsible for faxing medication orders to the pharmacy, that he had not been instructed that he was responsible for addressing medication authorization issues, that he had never dealt with requests for prior authorizations previously, that he had no way of knowing that the anti-seizure medication was not available on [redacted] and that there had been a breakdown in communication, as a result of which, the facility began enforcing a policy requiring that

communications be written in a log. The Subject's counsel argued that the facility did not take the investigation too seriously, as evidenced by the Subject's interrogation having been performed over the telephone, and that the Subject should not be unjustly saddled with a substantiation under all of these mitigating circumstances.

Despite these arguments, the evidence in the record clearly establishes that the Subject breached his duty to the Service Recipient to ensure that his medication was available. The Subject was the only medical professional overseeing the Service Recipient's medications and when the complication affecting the availability of prescribed medication arose, the Subject was responsible for proactively taking whatever steps were necessary to familiarize himself with the prior authorization issue and to resolve it.

Having determined that the Subject breached his duty to the Service Recipient, the issue then becomes whether the Subject's breach of duty 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. In this case, the Service Recipient suffered a seizure that was treated in a hospital emergency department, which certainly was a serious impairment of his physical, mental and emotional condition.

Accordingly, in the final analysis, based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect as specified in Allegation 1 of the substantiated report.

The report will remain substantiated and the next issue to be determined 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.

Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the Staff Exclusion List; nor will the fact that the Subject has a Substantiated Category 3 report be disclosed to entities authorized to make pre-employment inquiries with the Justice Center. However, the report remains subject to limited disclosure provisions pursuant to SSL § 496(2). The report will be sealed after 5 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 Sharon Golish Blum, Administrative Hearings Unit.

DATED: July 25, 2017
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge