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

In the Matter of the Appeal of [redacted]	**FINAL DETERMINATION AND ORDER AFTER HEARING**
Pursuant to § 494 of the Social Services Law	**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: August 21, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Charles S. DeAngelo, 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 #'s: [redacted]

Before: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Justice Center
2630 North America Drive
West Seneca, New York 14224
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.

[redacted]
By: Charles S. DeAngelo, Esq.
81 Forest Avenue
Post Office Box 590
Jamestown, New York 14702-0590

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains two reports substantiating [redacted] (the Subject) for neglect. The Subject requested that the VPCR amend the reports to reflect that the Subject is not a subject of the substantiated reports. 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 two "substantiated" reports[1] both dated [redacted] of neglect by the Subject of two Service Recipients.

2. The Justice Center substantiated the report under [redacted] 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 follow the medication administration policy by administering to a service recipient medication that had been pre-poured, without first ensuring that it was the correct medication and/or dosage, as a result of which the service recipient received medication intended for another service recipient, requiring her hospitalization.

The Justice Center does not make a finding as to any portion of this allegation. The findings for this allegation have been determined as part of [redacted].

Allegation 2

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to follow the medication administration policy by

[1] The two reports are related to the same incident, but do not share VPCR numbers.

administering to a service recipient medication that had been pre-poured, without first ensuring that it was the correct medication and/or dosage, as a result of which a service recipient received medication intended for another service recipient.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law§ 493(4)(c).

3. The Justice Center substantiated the report under [redacted] 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 follow the medication administration policy by administering to a service recipient medication that had been pre-poured, without first ensuring that it was the correct medication and/or dosage, as a result of which the service recipient received medication intended for another service recipient, requiring her hospitalization.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law§ 493(4)(b)

4. An Administrative Review was conducted and as a result the substantiated reports were retained.

5. The facility, located at [redacted], is an Individualized Residential Alternative (IRA) operated by the Office for People With Developmental Disabilities, (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center.

6. At the time of the alleged neglect, the Subject was employed by the facility as a Direct Support Assistant (DSA). (Hearing testimony of the Subject) The Subject was custodian as that term is so defined in Social Services Law § 488(2).

7. At the time of the alleged neglect, Service Recipient 1 had a moderate intellectual disability. Service Recipient 1's health was declining as she frequently suffered from dehydration, had underlying cardiac problems, suffered from frequent urinary tract infections and rapidly

progressing Alzheimer's disease with advancing dementia. (Hearing testimony of the Subject and Subject Exhibit C) Service Recipient 2 suffered from a mild intellectual disability, had a behavior support plan, and was prescribed psychotropic drugs including Lithium and Depakote. (Hearing testimony of the Justice Center Investigator)

8. The facility medication administration policy required, as is relevant here, that medications be prepared for administration at the time of administration and that medications were not to be "pre-poured." Staff were also prohibited from administering medication which they had not personally prepared. Finally, all staff who administered medication were required to use the "five rights of administration", and confirm: the right individual, right medication, right form, right dose, right route and right time. (Justice Center Exhibit 33) At the time of the alleged neglect the Subject was medication administration trained and had been so for several years. (Hearing testimonies of the Subject and the Justice Center Investigator)

9. At some time during the morning of [redacted], the Supervisor "pre-poured" the medications for each of the Service Recipients into an individual cup. The Supervisor then placed the cups on the bottom shelf of the nursing station cabinet. The Supervisor placed one cup below Service Recipient 1's slot and the other below Service Recipient 2's slot. (Justice Center Exhibit 39: [redacted] recorded audio interrogation of the Supervisor and Hearing testimony of the Subject) The Supervisor did not label the cups or make any other identifying marks on either cup. (Hearing testimony of the Subject)

10. Sometime later that morning, the Supervisor directed the Subject to administer medications to Service Recipients 1 and 2. The Subject did so and assumed that placement of unlabeled cups below the slots designated for the individual Service Recipients corresponded to that specific Service Recipient, and did not seek clarification from the Supervisor. The Subject

found that one cup of the "pre-poured" medication was sitting on the left side of the shelf and the other cup was sitting on the right side of the shelf. (Hearing testimony of the Subject) Ultimately, Service Recipient 1 received medication prescribed to Service Recipient 2, which included Lithium and Depakote. (Hearing testimony of the Justice Center Investigator and Subject Exhibit G) Service Recipient 2 received medications prescribed to Service Recipient 1. (Hearing testimony of the Justice Center Investigator)

11. After receiving the medications, Service Recipient 1 sat, and about one hour later Service Recipient 1 stood up and began to stagger. Staff 1 and the Subject assisted Service Recipient 1, and monitored her blood pressure and pulse, which were elevated. Staff 1 called 911 and the facility nurse was notified. (Hearing testimony of the Subject) Service Recipient 1 vacillated between "being responsive and not being responsive." (Justice Center Exhibit 15), and this decline was more pronounced than Service Recipient 1's typical presentation of altered mental status or lethargy. The Subject believed that Service Recipient 1's symptoms were side effects she suffered as a result of receiving the wrong medications, [redacted]. (Hearing testimony of the Subject) Service Recipient 2 did not evidence any symptoms, and was not hospitalized. (Hearing testimony of the Justice Center Investigator)

12. Service Recipient 1 was admitted to the hospital on [redacted], and the presenting problem was documented as an altered level of consciousness. (Justice Center Exhibit 37, p. 2) On [redacted], Service Recipient 1's Depakote and Lithium levels were measured. Service Recipient 1's Depakote was below the toxic level of 100 ug/ml, but, nonetheless, measurable at 77.4 ug/ml. (Subject Exhibit G, 10-21-14, Med Lab Report) Service Recipient 1's Lithium levels were determined to be at the low end of the reference range and were not at toxic levels. (Subject Exhibit D) On [redacted], a treating physician concluded that Service

Recipient 1's lithium levels were within normal range and were not toxic, (Subject Exhibit G, Physician Progress Note [redacted] time: 09:49) and her "adverse reaction" to the medication error had "completely resolved", and that Service Recipient 1 was "alert and back to baseline." (Subject Exhibit G, Physician Progress Note [redacted] time: 13:10)

13. In [redacted], a reviewing physician concluded that Service Recipient 1 suffered from "acute mixed drug intoxication, including lithium and valproic acid [Depakote]." (Justice Center Exhibit 13) The most common adverse reactions to Depakote include somnolence, meaning sleepiness. [2]

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 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 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 reports of neglect presently under review were substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an

[2] (Judicial Notice: FDA publication https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/017812s027,018421s025,018558s021lbl.pdf)

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)(h) as follows:

> "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 and 3, 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.
>
> (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 reports

that are the subject of the proceeding and that such act or acts constitute the category of neglect as set forth in the substantiated reports. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged neglect, the reports 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 reports constitutes the category of neglect as set forth in the substantiated reports.

If the Justice Center did not prove the neglect by a preponderance of the evidence, the substantiated reports 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 neglect in "Allegation 2" in the substantiated report under [redacted].

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as neglect in "Allegation 1" of the substantiated report under [redacted].

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1- 39) The investigation underlying the [redacted] substantiated report was conducted by Justice Center Investigator [redacted], who, at the time of the investigation, was employed by OPWDD. Justice Center Investigator [redacted] testified at the hearing on behalf of the Justice Center. The investigation underlying [redacted] substantiated report was conducted by Justice Center Investigator [redacted], who did not testify at the hearing.

The Subject testified in her own behalf and submitted Subject Exhibits A, B, C, D, E, F and G. Also admitted were ALJ Exhibits 1 and 2.

[redacted]

With regard to Allegation 2, the Justice Center established by a preponderance of the evidence that the Subject breached her duty to Service Recipient 2 and, as a result, she provided him with medications and or supplements prescribed to Service Recipient 1. The medications that Service Recipient 2 received are itemized in the Medication Administration Record. (Justice Center Exhibit 19) The evidence in the hearing record established that Service Recipient 2 suffered no adverse impact as a result of this incident.

However, while injury to a service recipient is not necessary to support a finding of neglect, there is no evidence in the record to conclude that the medications and/or supplements that Service Recipient 2 received were likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of Service Recipient 2. In the opinion of the Administrative Law Judge presiding over the hearing, evidence of likelihood could come in many forms, including consideration of US Food and Drug Administration data pertaining to medications and supplements. However, no such evidence was proffered.

[redacted]

With regard to Allegation 1, the Justice Center established by a preponderance of the evidence that the Subject breached her duty to Service Recipient 1 and, as a result, she provided her with medications and or supplements prescribed to Service Recipient 2. Had the Subject adhered to the facility medication administration policy (Justice Center Exhibit 33), this error would not have occurred. Because of this breach of duty, Service Recipient 1 received a number of medications that she was not prescribed, including Depakote and Lithium. Counsel for the

Subject argued that because Service Recipient 1 did not experience toxic levels of Depakote and Lithium and because Service Recipient 1 was experiencing progressing Alzheimer's disease and the associated dementia, it was Service Recipient 1's underlying health issues, and not the medication error, that caused Service Recipient 1 to be hospitalized. Indeed, there was evidence in the record that Service Recipient 1's dementia and perhaps other health problems had led to episodes similar to the one that triggered her hospitalization on [redacted].

However, the Subject testified that this episode was more significant and not the same as previous episodes. The presenting problem on admission to the hospital was documented to be an altered level of consciousness. (Justice Center Exhibit 37, p. 2) There was no definition for altered level of consciousness provided in the hearing record. The Administrative Law Judge presiding over the hearing took judicial notice of a definition of altered level of consciousness and read same into the hearing record. The definition appears on the MedicineNet[3] website, and reads as follows:

> An alteration in mental status refers to general changes in brain function, such as confusion, amnesia (memory loss), loss of alertness, disorientation (not cognizant of self, time, or place), defects in judgment or thought, unusual or strange behavior, poor regulation of emotions, and disruptions in perception, psychomotor skills, and behavior. While an altered mental status is obviously characteristic of a number of psychiatric and emotional conditions, medical conditions and injuries that cause damage to the brain, including alcohol or drug overdose and withdrawal syndromes, can also cause mental status changes. Confusion lethargy, delirium, dementia, encephalopathy, and organic brain syndrome are all terms that have been used to refer to conditions hallmarked by mental status changes.

Additionally, FDA guidance documents which counsel for the Justice Center presented, and which the Administrative Law Judge presiding over the hearing took judicial notice of, do note that somnolence or sleepiness is a common side effect of Depakote. This side effect tends to

[3] http://www.medicinenet.com/altered_mental_status/symptoms.htm

correlate with the Subject's characterization of the Service Recipient's episode, and with the Service Recipient's presentation upon admission to the hospital.

The day after her admission, Service Recipient 1's treating physician noted that her Lithium levels were not found at a toxic level, that her "adverse reaction" to the medication error had "completely resolved, and that Service Recipient 1 was "alert and back to baseline." (Justice Center Exhibit G, Physician Progress Note [redacted] time: 13:10) In [redacted], a reviewing physician concluded that Service Recipient 1 suffered from "acute mixed drug intoxication, including lithium and valrproic acid [Depakote]." (Justice Center Exhibit 13)

The Justice Center has established by a preponderance of the evidence that Service Recipient 1's hospitalization was, more likely than not, the result of her receiving a number of drugs that she was not prescribed, including Depakote and lithium. This error resulted in the altered mental status presentation of Service Recipient 1 and her hospitalization.

Additionally, at the hearing, the Justice Center took the position that additional prescription drugs which Service Recipient 1 was given by the Subject on [redacted], including: Clonidine, Zyprexa and Strattera also contributed to her hospitalization and asked the Administrative Law Judge to take judicial notice of FDA publications pertaining to those prescription drugs,[4] and the Administrative Law Judge did so. Clonidine and Zyprexa, like Depakote, are also reported to bring on somnolence.

All of these drugs carry the risk of multiple other side effects as well. While there was no proof from medical practitioners that the Clonidine, Zyprexa and Strattera contributed to the hospitalization of Service Recipient 1, it is more likely than not that Clonidine and Zyprexa,

[4] See: https://www.accessdata fda.gov/drugsatfda_docs/label/2014/020592s062021086s040021253s048lbl.pdf , https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/021411s048lbl.pdf, and https://www.accessdata.fda.gov/drugsatfda_docs/nda/2009/022331s000_Lbl.pdf.

inasmuch as they have the ability to cause somnolence, contributed to the altered mental status of Service Recipient 1, which ultimately led to her hospitalization. The fact that Service Recipient 1 was hospitalized established by a preponderance of the evidence that the Subject's breach of duty caused physical injury or serious or protracted impairment of her physical, mental or emotional condition to Service Recipient 1.

Additionally, irrespective of the hospitalization or the reasons for such, the multiple other side effects associated with Clonidine, Zyprexa and Strattera, Lithium and Depakote, as set forth in the FDA publication, are concerning enough to conclude that the Justice Center has established by a preponderance of the evidence that the Subject's breach of duty was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition Service Recipient 1.

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 in [redacted]. The substantiated report will not be amended or sealed.

The next issue to be determined is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. The Subject's counsel argues that the report should be properly categorized as a Category 3 act, and that the evidence does not support a finding that the Service Recipient's health, safety and/or welfare were seriously endangered because of the subject's omission.

Based upon the totality of the circumstances, the evidence presented and, in particular, the Service Recipient's underlying health conditions, the number of incorrectly administered medications, and the conclusions of medical professionals, it is concluded that the Service Recipient 1's health, safety and welfare were seriously endangered because 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 neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. However, substantiated Category 2 findings will be disclosed to OPWDD providers during pre-employment inquiries with the Justice Center. Category 2 conduct shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that Subject 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.

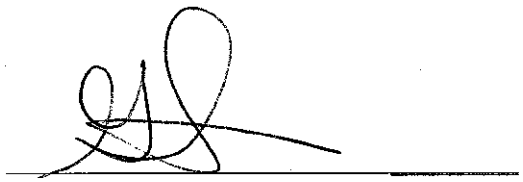
DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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 under [redacted] is properly categorized as a Category 2 act.

This decision is recommended by Gerard D. Serlin, Administrative Hearings Unit.

DATED: August 15, 2017
Schenectady, New York



Gerard D. Serlin, ALJ