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 is hereby adopted in its entirety.

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: December 12, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Erin Parker, 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: Gerard D. Serlin
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
2165 Brighton Henrietta Town Line Road
Rochester, New York 14623-2755
On: [redacted]

Parties: 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 between [redacted], at the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide adequate medical care to a service recipient by not promptly bringing her to the doctor after being notified that the day habilitation program had concerns about her being in pain.

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 [redacted], is an Individualized Residential Alternative (IRA), and is operated by the Office for People with Developmental Disabilities, 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 was employed as a Registered Nurse-2 (RN) with the provider agency. The Subject was assigned to two provider-agency-operated facilities, including the Facility. The Subject worked [redacted], Monday through Friday. Five service recipients resided in the Facility. (Hearing testimony of the Subject) 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 resident of the Facility, was in her sixties, had a profound intellectual impairment, Down syndrome and generally used a wheelchair, but could ambulate short distances with a walker. Also, relevant to the issues in this proceeding, are the Service Recipient's diagnosis of osteoporosis and history of seizure disorder and hip dysplasia. The Service Recipient did not speak, but made expressive vocalizations. (Hearing testimonies of Justice Center Investigator and the Subject) The Service Recipient had come to live at the Facility a few months prior to the alleged neglect. (Hearing testimony of the Subject) In [redacted], before the Service Recipient came to live at the Facility, she suffered from a left foot fracture. Shortly after arriving at the Facility, the Service Recipient experienced seizure activity which was preceded by her vocalizations. (Hearing testimony of the Subject)

7. The [redacted] Info Sheet, (Justice Center Exhibit 24) (the Log Book), contained service recipient specific documentation that travels with a service recipient from the Facility to the service recipient's day habilitation program. While the Log Book was the primary tool to facilitate communication between Facility staff and the day habilitation program staff, the Facility had no policy, and there was no requirement or expectation concerning Facility day staff review of notes made by day habilitation staff. However, the Facility evening shift was required

to record any service recipient concerns in the House Log (Justice Center Exhibit 23), a log that remained at the Facility, and was used for staff communication between shifts.

8. If a concern was documented in the Log Book by day habilitation staff, the only way that concern could be recorded in the House Log was if Facility evening staff reviewed the Log Book, and transcribed the relevant information into the House Log. (Justice Center Exhibit 25, audio recorded interrogation Supervisor 1)[1] The Facility RN would not normally review the Log Book. (Hearing testimonies of the Justice Center Investigator and the Subject), but would, from time to time, review the House Log. (Hearing testimony of the Subject) All Facility staff had the telephone number for the Facility RN and access to the RN via a pager. (Hearing testimony of the Subject)

9. The Facility RN's interaction with the day habilitation program was limited to advising habilitation staff of identified service recipient medical concerns and of upcoming medical appointments which would necessitate transporting the service recipient from the day habilitation program. (Hearing testimony of the Subject)

10. On [redacted], the Subject was notified by Facility Supervisor 1 that staff at the Service Recipient's day habilitation program expressed that the Service Recipient was making unusual noises when transitioning to her wheel chair, from her walker. On the same date, around dinner time, the Subject visited the Service Recipient at the Facility and observed the Service Recipient ambulate; specifically, she observed the Service Recipient stand from the dinner table and then walk with the assistance of her walker, to a living room chair. The Subject noted nothing out of the ordinary and the Service Recipient made no noises. The Subject inquired of evening Facility staff as to whether they had heard the Service Recipient make any noises, and staff denied

[1] Supervisor 1 is [redacted].

that they had. (Hearing testimony of the Subject) Facility Supervisor 1 was present for all, or a portion of the evaluation. (Justice Center Exhibit 25, audio recorded interrogation Supervisor 1)

11. The Subject documented the concerns raised by Facility Supervisor 1, as well as her visit to the Facility on [redacted], in the DDSO notes, often referred to in the record as the progress notes. (Justice Center Exhibit 22) Specifically, the Subject documented that it was reported to her that the Service Recipient had made a loud unusual screeching noise at program when going from a sitting, to a standing position. The Subject also documented that she observed the Service Recipient and found no issues. (Justice Center Exhibit 24 and Hearing testimony of the Justice Center Investigator)

12. The following morning, [redacted], the Subject went to the Facility and observed the Service Recipient while she was lying in bed. The Service Recipient did not appear to be in distress. The Subject asked the Facility day staff if the Service Recipient's bed posture was consistent with the Service Recipient's norm, and staff indicated that it was. The Service Recipient was cheerful and made no unusual vocalizations. (Hearing testimony of the Subject)

13. Sometime later that day, while at day habilitation program, the Service Recipient made a "couple of loud noises," and ultimately the physical therapist "checked her out." Day habilitation staff documented those observations in the Log Book. (Justice Center Exhibit 24)

14. On [redacted], staff at the day habilitation program noted that the Service Recipient "cried on and off." Day habilitation program staff documented those observations in the Log Book. On [redacted], staff at the day habilitation program observed that the Service Recipient was "crying and yelling out [,] throughout the day. We believe she is in pain." (Justice Center Exhibit 24)

15. On [redacted], staff at the day habilitation program wrote in the Log Book that

the Service Recipient was "upset and tired-loud noises (in pain) … [the Service Recipient] yelled out all day [,] cried (tears) off and on through the day. [The Service Recipient] has been yelling [and] crying for the last week. She also was walking w/her left hip [and] buttocks lifting up." (Justice Center Exhibit 24)

16. On [redacted], staff at the day habilitation program documented in the Log Book that "the staff … are very concerned about [the Service Recipient.] She has been screaming and crying all week. We have expressed our concern. We feel that we are being ignored … We feel that [the Service Recipient] is in pain. [The Service Recipient] keeps taking her left shoe off." (Justice Center Exhibit 24)

17. After [redacted], Facility Supervisor 1 received two additional calls from staff at the day habilitation program expressing concern about the Service Recipient being in pain. However, except for [redacted], Facility Supervisor 1 did not communicate those concerns to the Subject. (Hearing testimony of the Subject) Facility Supervisor 1 was out of work on vacation for one week beginning on [redacted], or perhaps for three days of training beginning on that date, and in any event, was not in the Facility on [redacted]. (Justice Center Exhibit 25, audio recorded interrogation of Facility Supervisor 1 and Hearing testimony of the Justice Center Investigator)

18. Between [redacted], no Facility staff documented in the House Log any concerns about the Service Recipient yelling, screaming or vocalizing pain. Additionally, no Facility staff reviewed the Log Book and documented in the Facility Log that staff from the day habilitation program had expressed a concern, or had contacted the Facility staff with a concern. (Justice Center Exhibit 23)

19. On [redacted], the Service Recipient had a previously scheduled primary care medical appointment. The Subject and another staff accompanied the Service Recipient to this appointment. The primary care physician conducted a basic vital sign assessment of the Service Recipient, but the physician did not observe the Service Recipient ambulate or transition from sitting to standing. (Hearing testimony of the Subject)

20. After the Service Recipient's appointment with her primary care provider on [redacted], the Subject received a phone call from the day habilitation program RN. The habilitation program RN asked the Subject whether the physician had addressed the Service Recipient's pain. The Subject replied that she was unaware of any pain issues. The Subject then called the primary care physician's office and made the next available appointment for the Service Recipient, for [redacted]. The Subject next called the day habilitation program, conveyed the date of the appointment and documented the conversation and follow-up action in the Facility progress notes. (Justice Center Exhibit 22 and Hearing testimony of the Subject)

21. On [redacted], the Service Recipient had a previously scheduled neurology appointment to address her seizure disorder. The Subject accompanied the Service Recipient to this appointment. The Service Recipient was examined by the neurologist who did not assess the Service Recipient's vocalizations or locomotion. (Justice Center Exhibit 14) The neurologist noted among other observations that the Service Recipient was moving all extremities spontaneously, "and at least antigravity." (Justice Center Exhibit 15 and Hearing testimony of the Subject) However, the neurologist did not observe the Service Recipient ambulate. (Hearing testimony of the Subject) The Subject observed the Service Recipient stand from the chair and pivot at least twice during this visit, and the Service Recipient did not yell or give cause for concern. (Hearing testimony of the Subject)

22. On [redacted], the Subject received a phone call from day habilitation program and they reported that the Service Recipient was in pain and was screaming. The Subject called the day staff at the Facility and inquired as to whether the Service Recipient appeared to be in pain on that morning; staff indicated that she did not. The Subject then called the day habilitation program and asked for a physical therapy assessment and body check, and conveyed that she would take the Service Recipient to an urgent care facility. (Hearing testimony of the Subject) The Service Recipient was examined by the day habilitation physical therapist, who noted that the Service Recipient was avoiding putting weight on her left foot and that she exhibited a "yelping response" upon palpation of two toes on her left foot. (Justice Center Exhibit 21) The Subject then accompanied the Service Recipient to an urgent care facility where the Service Recipient's left foot was x-rayed. It was at time that the Subject heard, for the first time, the Service Recipient scream loudly when the Service Recipient stood up from her wheelchair. (Hearing testimony of the Subject)

23. The Service Recipient was seen by an orthopedist and that provider compared the current x-rays with the x-rays from the previous [redacted] when the Service Recipient had fractured her left foot, when she resided in another facility. (Hearing testimony of the Subject) The Service Recipient was diagnosed with a closed ankle fracture. (Justice Center Exhibit 20) As a result, the Service Recipient was prescribed an immobilization boot. (Hearing testimony of the Subject)

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 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 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 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 neglect alleged in the substantiated report that is the subject of the proceeding and that such act constitutes 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 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 many exhibits obtained during the investigation. (Justice Center Exhibits 1-25) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Justice Center did not establish by a preponderance of the evidence that the Subject breached her duty to the Service Recipient. The compelling evidence in the record established that the Subject reacted appropriately on [redacted], after being alerted to a concern of vocalizations upon transitioning by the Service Recipient. The Subject observed the Service Recipient ambulate on the evening of [redacted], and again observed her on the morning of [redacted], while she was lying in bed. While staff at the day habilitation program documented that they observed

ongoing crying out and other verbal expressions of pain, staff at the Facility did not document any concerns in either the House Log or the Service Recipient's progress notes during the relevant time. The matter was further complicated by the fact that the evening staff at the Facility apparently failed to review the Log Book and, therefore, were unaware of escalating concerns being raised by the day habilitation staff.

Staff at the day habilitation program called the Facility Supervisor 1 at least two more times after [redacted], and before [redacted], to express concerns. Despite the claims of Supervisor 1 during her interrogation that she relayed the concerns of day habilitation staff to the Subject at least two additional times after [redacted], Supervisor 1's claim is wholly incredible. Supervisor 1 was unable to provide any documentation of receiving those phone calls and failed to document in any record, that she ever alerted the Subject to those concerns. Supervisor 1 was unable to provide dates that she received the calls from day habilitation staff or dates when she relayed the information to the Subject. The ALJ presiding over the hearing having listened to the recorded audio interrogation of Supervisor 1 concludes that her claims are not credited evidence.

The Subject testified credibly under oath that she received only one communication from Supervisor 1, and that communication occurred on [redacted]. The [redacted], communication referenced unusual verbalization by the Service Recipient potentially associated with transitioning from sitting to standing. The Subject took appropriate action on [redacted] and [redacted]. However, the Service Recipient did not present with any unusual behaviors, and did not appear to be in distress.

While the day habilitation staff made entries in the Log Book characterizing pain and/or vocalizations, evidence in the record suggests that on [redacted], the Service Recipient was assessed by the day habilitation Physical Therapist who found nothing of significance or, in the

alternative, failed to document a finding. This is noteworthy for two reasons. Firstly, staff at the day habilitation program wrote in the Log Book on [redacted], that the Service Recipient had been in pain "all week." However, for reasons not established in the record, the portion of the Log Book admitted into evidence contains no entries pertaining to [redacted]. (Justice Center Exhibit 24)

Secondly, when, at the request of the Subject, the day habilitation program Physical Therapist examined the Service Recipient on [redacted], the Physical Therapist made extensive findings consistent with the ultimate diagnosis. Ostensibly, the Physical Therapist's findings after the [redacted] assessment were different than those of the [redacted] physical therapy assessment. The evidence supports the conclusion that the Service Recipient did not, for whatever reason, consistently exhibit symptoms of distress or pain during the relevant time.

The preponderance of the evidence in the record does not support the conclusion that the Subject breached her duty to the Service Recipient. The first time the Subject appears to have been aware that there was a potential issue with the Service Recipient experiencing pain was [redacted], when she received a phone call from the day habilitation RN. This phone call came after the Subject returned from a routine primary care physician appointment for the Service Recipient. The Subject immediately scheduled the next available appointment with the Service Recipient's primary care provider to address the pain.

The following day, the Subject accompanied the Service Recipient to her neurology appointment and, while the Subject did not raise the specific concerns of pain with the neurologist, the purpose of the appointment was to assess the Service Recipient's seizure disorder. The Subject was aware that the Service Recipient had made vocalizations just before having a seizure, when she first came to live at the Facility. The neurological exam was unremarkable and there is no

evidence that the Service Recipient was in distress. Additionally, the Subject observed the Service Recipient transition from a seating to a standing position during this visit, and this transition was likewise unremarkable.

On [redacted], the Subject was alerted by the staff at the day habilitation program that the Service Recipient appeared to be in significant pain and the Subject took all appropriate measures to ensure that the Service Recipient received appropriate medical care.

After considering all of the evidence, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed neglect alleged. The substantiated report will be amended or 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 Gerard D. Serlin, Administrative Hearings Unit.

DATED: December 5, 2017
Schenectady, New York

Gerard D. Serlin, ALJ