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

In the Matter of the Appeal of

FINAL
DETERMINATION
AND ORDER
AFTER HEARING

Pursuant to § 494 of the Social Services Law

Adjud. Case #:

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: January 3, 2018

Schenectady, New York

David Molik

Administrative Hearings Unit

ant mole

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit

, Subject

Nathaniel Charny, Esq.

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

In the Matter of the Appeal of

RECOMMENDED DECISION AFTER HEARING

Pursuant to § 494 of the Social Services Law

Adjud. Case #:

Before: Elizabeth M. Devane

Administrative Law Judge

Held at: Administrative Hearings Unit

New York State Justice Center for the Protection

of People with Special Needs 4 Burnett Boulevard, Second Floor Poughkeepsie, New York 12601

On:

Parties: New York State Justice Center for the Protection

of People with Special Needs

161 Delaware Avenue

Delmar, New York 12054-1310 By: Thomas C. Parisi, Esq.

By: Nathaniel Charny, Esq. Charny & Associates 9 West Market Street

Rhinebeck, New York 12572

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating (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:

- The VPCR contains a "substantiated" report dated
 of neglect by the Subject of the Service Recipient.
- 2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Allegation 1

It was alleged that on the located at the located a

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

- An Administrative Review was conducted and as a result the substantiated report was retained.
 - 4. The facility, the , located at , is an IRA providing 24-hour care and supervision

to service recipients with developmental disabilities, is overseen and administered by the and is 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. (Hearing testimony of Justice Center Investigator ; Justice Center Exhibit 6)

- 5. At the time of the alleged neglect, the Subject was employed at the IRA, had worked for OPWDD for approximately 30 years as a Direct Support Assistant (DSA), and was trained and certified in medication administration. The Subject's duties included assisting the service recipients with all activities of daily living, transporting, and administering medication to service recipients. (Hearing testimony of Justice Center Investigator ; Hearing testimony of the Subject; Justice Center Exhibits 6, 25 and 26)
- 6. At the time of the alleged neglect, the female Service Recipient was 90 years old and had resided at the IRA since 1990. The Service Recipient's diagnoses included mild intellectual disability, behavior disorder and visual impairment and the Service Recipient suffered from constipation. The Service Recipient relied on staff for all medical needs including medication administration. (Hearing testimony of Justice Center Investigator ; Justice Center Exhibits 6, 21, 22, 23 and 25)
- 7. The Service Recipient's Medication Administration Record (MAR) directed that, along with other medications, the Service Recipient be administered one capsule of docusate sodium (Colace) by mouth three times every day at specified times, 8:00 a.m., 12:00 noon and 8:00 p.m., to treat constipation. (Hearing testimony of Justice Center Investigator Hearing testimony of Subject; Justice Center Exhibits 6, 7, 8, 16 and 25)
 - 8. Pursuant to the Medication Administration Policy Manual, medication

dispensed must be recorded immediately after administration. If a medication is not administered, that fact must be documented on the Medication/Treatment Record, and the Continuing Notes, and the staff administering medications must circle their initials in the appropriate box on the Medication/Treatment Record, as well as record the problem, the name of the physician or nurse notified and the plan of action recommended in the Continuing Notes. (Hearing testimony of Justice Center Investigator ; Hearing testimony of the Subject; Justice Center Exhibits 6 and 24).

- 9. On the Subject worked at the IRA from the Subject began her shift at the IRA at 7:00 a.m. and worked until at least 3:00 p.m. (Hearing testimony of Justice Center Investigator ; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 8, 16 and 20)
- 10. At noon on ______, a Developmental Aide (DA 1), dispensed the last dose of Colace from the blister pack to the Service Recipient then left the blister pack out next to the medication cabinet to indicate to the other employees that there was no more Colace left. (Hearing testimony of Justice Center Investigator ______; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 8, 9 and 25)
- 11. The DA 1 verified with a DSA (DSA 1) that a refill request was sent to the pharmacy and asked DSA 1 to pick up the medication. All staff were authorized to request prescription refills and pick prescriptions up from the pharmacy. (Hearing testimony of Justice Center Investigator ; Hearing testimony of the Subject; Justice Center Exhibits 6 and 25)
- 12. On at 8:00 p.m. and again on at 8:00 a.m., the Subject signed and initialed the MAR indicating that she dispensed Colace to the Service Recipient

(Hearing testimony of Justice Center Investigator ; Hearing testimony of the Subject; Justice Center Exhibits 6, 8, 9, 16 and 25)

- Nurse (RN) that there was no Colace available to dispense to the Service Recipient for her scheduled noon dose. (Hearing testimony of Justice Center Investigator ; Justice Center Exhibits 6, 9 and 25)
- 14. Around that same time, the Service Recipient vomited and was hypotensive. Emergency Services were called and took the Service Recipient to a local hospital. An x-ray of the Service Recipient's abdomen showed that she was constipated. The Service Recipient was prescribed medication for nausea and vomiting and additional medication for constipation. (Hearing testimony of Justice Center Investigator ; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 10, 11, 12, 13, 14, 17 and 25)

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

because 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 neglect shall be categorized into categories including Category 3 pursuant to SSL § 493(4)(c), which is defined as:

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 proved by a preponderance of the evidence that the Subject committed neglect as described in Allegation 1 in the substantiated report, by failing to notify a nurse that the Service Recipient's medication had run out and by completing the medication administration record incorrectly, resulting in the Service Recipient missing three doses of her medication.

The Justice Center has not proved by a preponderance of the evidence that the Subject committed neglect as described in Allegation 1 in the substantiated report by failing to pick up the medication at the pharmacy.

To sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that her breach either 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))

In support of its substantiated findings, the Justice Center presented several documents obtained during the investigation (Justice Center Exhibits 1 - 24 and 26 - 28) as well as an audio CD of interviews (Justice Center Exhibit 25). The investigation underlying the substantiated report was conducted by Justice Center Investigator , 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 no additional evidence.

It is not in dispute that, at the time of the alleged neglect, the Subject was employed as a DSA at the IRA and was a custodian as that term is defined in Social Services Law § 488(2). (Hearing testimony of Justice Center Investigator; Hearing testimony of the Subject)

The evidence establishes that the Subject was trained and certified in medication administration. (Hearing testimony of Justice Center Investigator Hearing testimony of the Subject; Justice Center Exhibits 6 and 26) When a medication is not available or is not dispensed to a service recipient, specific steps must be taken. (Hearing testimony of Justice ; Hearing testimony of the Subject; Justice Center Exhibits 6 Center Investigator and 24) The Service Recipient was to receive Colace three times per day for constipation and the last available dose was dispensed on at noon. (Hearing testimony of Justice Center Investigator ; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 8, 16 and 25) The Subject's uncircled initials on the Service Recipient's MAR reflect that the Subject dispensed Colace to the Service Recipient on at 8:00 p.m. and on at 8:00 a.m. (Hearing testimony of Justice Center Investigator ; Hearing testimony of the Subject; Justice Center Exhibits 6 and 16) The Subject did not circle her initials on the Service Recipient's MAR for those entries or indicate in the Continuing Notes that the Colace was not dispensed to the Service Recipient and did not notify a physician or the RN of that fact.

The Subject admitted that after she discovered there was no more Colace available, she should have notified that RN. The Subject also admitted that she should have circled her initials in the MAR on at 8:00 p.m. and on at 8:00 a.m. to indicate that the medication was not dispensed, but testified that she forgot to do so. The Subject testified

that she did not notify the RN on the evening of because it was too late and that she was going to do so the next day. The Subject testified that, although the RN was at the IRA the morning of the RN that there was no more Colace available because she was busy with her responsibilities to other service recipients and forgot. The Subject's testimony is credited evidence. (Hearing testimony of the Subject)

The weight of evidence in the record and hearing testimony support a finding by a preponderance of the evidence that the Subject breached her duty by failing to notify a nurse that the Service Recipient's medication had run out and by filling out the medication administration record incorrectly.

After the DA 1 administered the last available dose of medication and verified that a refill was submitted to the pharmacy, DA 1 asked DSA 1 to pick up the prescription from the pharmacy. However, DSA 1 stated she, in turn, later asked the Subject to pick up the medication from the pharmacy. The Subject testified that DSA 1 never asked her to pick up the prescription. The Subject's testimony is credited evidence.

The weight of evidence in the record and hearing testimony do not support a finding by a preponderance of the evidence that the Subject breached her duty by failing to pick up the medication at the pharmacy.

The Subject's breach by failing to notify a nurse that the Service Recipient's medication had run out and by completing the medication administration record incorrectly, was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. As a result of the Subjects neglect, the Service Recipient failed to receive three doses of Colace which likely resulted in the Service Recipient vomiting, becoming hypotensive, and requiring a trip to the hospital. An x-ray of the Service Recipient's abdomen

showed that she was constipated and the Service Recipient was prescribed medication for nausea and vomiting, and additional medication for constipation. (Hearing testimony of Justice Center Investigator ; Hearing testimony of the Subject; Justice Center Exhibits 6, 7,10,11,12,13,14,17 and 25)

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 as described in Allegation 1 in the substantiated report, by failing to notify a nurse that the Service Recipient's medication had run out and by completing the medication administration record incorrectly. The substantiated report will not be amended and 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 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 NY SSL § 496(2). This report will be sealed after five years.

that the substantiated report dated 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 Elizabeth M. Devane, Administrative Hearings Unit.

DATED: January 2, 2018

Schenectady, New York

Elizabeth M. Devane

Administrative Law Judge