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 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 Elizabeth M. Devane, ALJ, Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: **October 15, 2018**
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge

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

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: John T. Nasci
Administrative Law Judge

Held at: New York State Office Building
333 East Washington Street, Room 115
Syracuse, New York 13202
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: Peter Zisser, Esq.

[redacted]

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] and [redacted] (the Subjects) for neglect. The Subjects requested that the VPCR amend the report to reflect that the Subjects are not subjects 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 Subjects of a Service Recipient.

2. The Justice Center substantiated the report against the Subject [redacted]. The Justice Center concluded that:

Allegation 1

It was alleged that on [redacted], at the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide proper supervision to the service recipient by not immediately contacting emergency medical services when the service recipient fell, as required by policy, which delayed her medical treatment, after which she passed away.

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

3. The Justice Center substantiated the report against the Subject [redacted]. The Justice Center concluded that:

Allegation 1

It was alleged that on [redacted], at the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide proper supervision to the service recipient by not questioning

> or determining the circumstances surrounding [the Service Recipient] apparent seizure, which resulted in a delay in her medical treatment after [the Service Recipient] fell, after which time she passed away.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

4. An Administrative Review was conducted and, as a result, the substantiated report was retained.

5. The facility, [redacted], located at [redacted], is a residential facility for the care and treatment of developmentally disabled people needing enhanced care. The ICF is operated by [redacted], which is certified by the New York State Office for People With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted], Justice Center Investigator (Investigator))

6. At the time of the alleged neglect, Subject [redacted] was employed by [redacted] as a Direct Service Professional (DSP) and had been employed by [redacted] for nine years. (Hearing testimony of Subject [redacted]) Subject [redacted] was a custodian as that term is defined in Social Services Law § 488(2).

7. At the time of the alleged neglect, Subject [redacted] was employed by [redacted] as a Direct Service Professional (DSP) and had been employed by [redacted] for twenty-two years. (Hearing testimony of Subject [redacted]) Subject [redacted] was a custodian as that term is defined in Social Services Law § 488(2).

8. At the time of the alleged neglect, the Service Recipient was a sixty-six year old female resident of the facility. The Service Recipient was diagnosed with severe mental retardation and Down syndrome, and had a history of petit mal seizures. Prior to [redacted],

the Service Recipient last suffered a seizure on [redacted]. (Justice Center Exhibits 20 and 21; and Hearing testimony of the Investigator)

9. On [redacted], the Subjects were assigned and worked the midnight to 10:00 a.m. shift, at the ICF. The Subjects' duties were to provide direct care for the ICF's resident service recipients including the Service Recipient. (Justice Center Exhibits 23 and 39: audio recording of Justice Center interview of Subjects [redacted] and [redacted]; and Hearing testimony of the Subjects [redacted] and [redacted])

10. On [redacted], at approximately 5:00 a.m., the Service Recipient awoke and started making noises, which triggered Subject [redacted] to enter her room and move her to the bathroom via a wheelchair. Once in the bathroom, Subject [redacted] helped the Service Recipient onto the toilet. Subject [redacted] then turned away from the Service Recipient to grab a washcloth and heard the Service Recipient fall onto the floor. When Subject [redacted] turned back around, she observed the Service Recipient lying on her side on the bathroom floor. The Service Recipient was twitching and digging at her leg with one hand, her eyes were rolled back, she had defecated and was urinating on the floor. (Justice Center Exhibits 10, 14, 27 and 39: audio recording of Justice Center interview of Subjects [redacted] and [redacted]; and Hearing testimony of Subject [redacted])

11. Upon noticing that the Service Recipient had fallen, Subject [redacted] yelled to Subject [redacted] to come to the bathroom to assist her. Both Subjects interpreted the Service Recipient's condition and actions to be symptoms of an ongoing seizure. The Service Recipient became responsive after one minute to one and one-half minutes, her eyes stopped rolling after approximately one and one half minutes and her other symptoms ceased after two minutes. Thereafter, the Service Recipient returned to her normal behavior and demeanor. (Justice

Center Exhibits 5, 25, 27 and 39: audio recording of Justice Center interview of Subjects [redacted] and [redacted]; and Hearing testimony of Subject [redacted])

12. The Subjects monitored the Service Recipient in place on the floor for fifteen minutes after the fall. While monitoring the Service Recipient, the Subjects both observed injuries on the Service Recipient including a small abrasion and bump on her forehead, a scrape/scratches on her left hip/upper thigh and bruises on her right ankle/back of leg. (Justice Center Exhibits 10, 14 and 39: audio recording of Justice Center interview of Subjects [redacted] and [redacted]; and Hearing testimony of Subject [redacted])

13. During the fifteen minutes of monitoring, Subject [redacted] left the bathroom briefly to retrieve equipment necessary to perform a check of the Service Recipient's vital signs. Fifteen minutes after the fall, Subject [redacted] performed the vital signs check, then left the bathroom again to telephone the Nurse-On-Call (NOC)[1] to report to the NOC the Service Recipient's fall, the Service Recipient's seizure symptoms, the Service Recipient's injuries and the Service Recipient's vital signs. (Justice Center Exhibits 5, 14, 25, 27 and 39: audio recording of Justice Center interview of Subjects [redacted] and [redacted]; and Hearing testimony of Subject [redacted])

14. Subject [redacted] reported to the NOC that the Service Recipient's vital signs were normal and that she was acting her usual self. Subject [redacted] also reported to the NOC that the Service Recipient may have passed out on the toilet before falling. The NOC instructed Subject [redacted] to move the Service Recipient to her bed and to continue to monitor her. The NOC also instructed Subject [redacted] to administer Tylenol for any discomfort the Service Recipient was experiencing. (Justice Center Exhibits 14, 27 and 39: audio

[1] The NOC was [redacted], a Registered Nurse employed by [redacted].

recording of Justice Center interview of Subject [redacted]; and Hearing testimony of Subject [redacted])

15. In the evening of [redacted], the Service Recipient was taken to [redacted] Medical Center in [redacted] where she was diagnosed with a fracture of her first cervical. Later that evening the Service Recipient was transported to the [redacted] Medical Center in [redacted] where she was further evaluated and further diagnosed with a C1 Jefferson fracture. The Service Recipient died later that day. (Justice Center Exhibits 17, 18, 32 and 39: audio recording of Justice Center interview of DSP [redacted], and DSP [redacted])

16. The Service Recipient's death was attributed to a cervical vertebral fracture caused by blunt impact from her fall from the toilet on [redacted]. (Justice Center Exhibits 19 and 20)

17. [redacted] maintains a policy entitled "A Guidebook for When to Call the NOC" (policy), of which the Subjects were both trained and familiar. The policy contained protocol that [redacted] staff were required to follow concerning, in pertinent part, when service recipients suffer from head injuries and when service recipients suffer from seizures. (Justice Center Exhibit 37)

18. The [redacted] protocol for seizures required, in pertinent part, that, in the event a service recipient has a known active seizure disorder (one seizure at least monthly), and has a seizure that follows the service recipient's normal pattern, staff were to wait fifteen minutes and then take the vital signs of the service recipient. If the vital signs were normal, and the seizure lasted no more than five minutes, then staff were not required to call the nurse. In the event that a service recipient, who was diagnosed with seizure disorder but who did not have active seizures, had a seizure, staff were required to notify the nurse immediately. (Justice Center Exhibit 37, pg10)

19. The [redacted] protocol for head injuries required, in pertinent part, that staff "Call the

NOC" in the event that a service recipient suffers from a "Minor head injury – a head injury obtained from grazing ones [sic] head on an object or falling, leaving a bruise, scrape or swelling," or from "falls-where bruising is noted or the head was hit." (Justice Center Exhibit 37, pg7)

ISSUES

- Whether the Subjects have 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 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 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 Category 3, which are 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 Subjects committed the acts of neglect alleged in the substantiated report that are the subject of the proceeding and that such acts constitute 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 acts of neglect cited in the substantiated report constitute 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 Subjects committed the acts, described as "Allegation 1" for each of the Subjects 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 through 37) The Justice Center also presented audio recordings of the Justice Center Investigator's interview of witnesses and of the Subjects. (Justice Center Exhibits 38 and 39) The investigation underlying the substantiated report was conducted by the Investigator, who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subjects each testified in their own behalf and presented no other evidence.

Allegation 1 – Subject [redacted]

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject [redacted] action, inaction or lack of attention breached a duty that 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 Recipients. (SSL §488(1)(h))

The Justice Center contends that Subject [redacted] had a duty to immediately contact emergency medical services when the Service Recipient fell off the toilet, that her failure to do so was a breach of duty which delayed her medical treatment, ultimately resulting in her death.

Subject [redacted] argues that she followed [redacted] policy by waiting fifteen minutes after the onset of the Service Recipient's seizure and, thereafter, she contacted the NOC to recount

what happened and to relay the Service Recipient's vital signs, and by following such policy, she did not breach her duty.

The record reflects that prior to [redacted], the Service Recipient's latest seizure was on [redacted]. Consequently, the Service Recipient did not have active seizures, which was defined by [redacted] policy as at least one seizure monthly. (Justice Center Exhibit 37, pg10) [redacted] protocol for a service recipient suffering from a seizure, who did not have active seizures, required staff to notify the NOC immediately. (Justice Center Exhibit 37, pg10) Since the Service Recipient did not have active seizures, and suffered from an apparent seizure, [redacted] protocol required Subject [redacted] to notify the NOC immediately. Instead, Subject [redacted] waited fifteen minutes, as [redacted] policy allowed in the case of a service recipient who did have active seizures. Consequently, Subject [redacted] breached her duty.

Because the Service Recipient fell, hit her head and suffered a small abrasion and bump on her forehead, a minor head injury (as defined by [redacted] policy), Subject [redacted] was required by [redacted] policy to "Call the NOC." (Justice Center Exhibit 37, pg7) [redacted] policy did not require Subject [redacted] to immediately contact emergency medical services and [redacted] policy prescribed no timeframe for making a call to the NOC. Because the record reflects that Subject [redacted] called the NOC fifteen minutes after the fall, it cannot be concluded that she breached this duty.

Because it is found that Subject [redacted] breached her duty concerning contacting the NOC regarding the Service Recipient's seizure, it must be determined whether or not Subject [redacted] breach 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. The Justice Center presented no evidence concerning the effect of Subject [redacted]

[redacted] fifteen-minute delay in contacting the NOC to report the Service Recipient's seizure. Consequently, it cannot be found that the Justice Center met its burden of proving that Subject [redacted] 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.

It should be noted that, while there is a good amount of evidence in the record concerning the Service Recipient's injuries and death, the record reflects that both were attributed to the Service Recipient's fall from the toilet and not the Service Recipient's seizure. (Justice Center Exhibits 19 and 20) Because Subject [redacted] is not found to have breached [redacted] policy concerning head injuries, Subject [redacted] cannot be found to have committed neglect in this regard.

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that Subject [redacted] committed the neglect alleged. The substantiated report will be amended and sealed.

Allegation 1 – Subject [redacted]

The Justice Center contends that Subject [redacted] had a duty to question or determine the circumstances surrounding the Service Recipient's apparent seizure, and that her failure to do so was a breach of duty which delayed her medical treatment, ultimately resulting in her death.

Subject [redacted] argues that, upon entering the bathroom and seeing the Service Recipient's symptoms, she determined that the Service Recipient was having a seizure. She further argues that thereafter she and Subject [redacted] followed [redacted] seizure policy by monitoring the Service Recipient for fifteen minutes, then contacting the NOC.

As stated above, by waiting fifteen minutes after the onset of the Service Recipient's apparent seizure, the Subjects did not follow [redacted] policy. However, the Justice Center did not allege

that Subject [redacted] breached her duty by not following this policy. Instead, the Justice Center alleged that Subject [redacted] breached her duty by not questioning or determining the circumstances surrounding the seizure.

The Justice Center presented no evidence, and there is no other evidence in the record, of any duty that Subject [redacted] was under to question or determine the circumstances surrounding the Service Recipient's seizure. Furthermore, the Justice Center did not provide an explanation of what "questioning or determining circumstances surrounding a seizure" means.

The [redacted] policy that is found in the record goes no further than obligating Subject [redacted], and other [redacted] staff, to recognize when a service recipient is suffering from a seizure and to either contact the nurse immediately or to monitor the Service Recipient for fifteen minutes, take vital signs and then call the NOC, depending on whether or not the service recipient had suffered from known active seizures.

The record reflects that, upon entering the bathroom, Subject [redacted] recognized that the Service Recipient was exhibiting signs of a seizure and her conduct thereafter was based on her assumption that the Service Recipient was having a seizure. After recognizing that the Service Recipient was experiencing a seizure, Subject [redacted] was not required by [redacted] policy to inquire or investigate further by questioning or determining the circumstances surrounding the seizure.

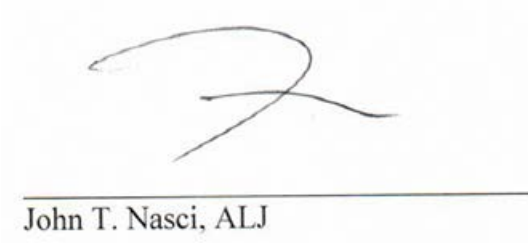
Consequently, the Justice Center has not established that Subject [redacted] had a duty to question or determine the circumstances surrounding the Service Recipient's apparent seizure.

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that Subject [redacted] committed the neglect alleged. The substantiated report will be amended and sealed.

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

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

DATED: September 7, 2018
Schenectady, New York



John T. Nasci, ALJ