**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 23, 2018**
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
John McPhilliamy, 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: Todd Sardella, Esq.

[redacted]
By: John McPhilliamy, Esq.
Ahmuty, Demers & McManus
Attorneys at Law
200 I.U. Willets Road
Albertson, New York 11507

## 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] of neglect by the Subject of a Service Recipient.

2. The Justice Center's Report of Substantiated Finding 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 take proper action and/or communicate to other nursing or medical staff a medical concerns brought to your attention.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

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

4. The facility, located at [redacted], is a fourteen bed Individualized Residential Alternative (IRA) for service recipients with increased medical needs, that is operated by [redacted], which is certified by the New York State Office for People With Developmental Disabilities (OPWDD) and is, therefore, a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of facility Quality Improvement Specialist [redacted])

5. At the time of the alleged neglect, the Service Recipient was an alert, verbal, wheelchair bound adult female with a complicated medical history that included diagnoses of cerebral palsy, epilepsy, anxiety, depression, intellectual disability and dementia. (Hearing testimony of facility Quality Improvement Specialist [redacted])

6. At the time of the alleged neglect, the Subject had been employed as a facility Registered Nurse (RN) for approximately seven years and she regularly worked from [redacted] (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

7. At approximately 2:30 p.m. on [redacted], when the Service Recipient was participating in the onsite Day Habilitation Program (Day Hab), the Day Hab Team Leader assisted DSP 1 in toileting the Service Recipient and both staff noticed that her urine had an unusually strong odor. (Justice Center Exhibits 6, 21, 22, 23 and 29)

8. The Day Hab Team Leader approached the nurse's station and advised the Subject that the Service Recipient's urine smelled unusually strong. The Subject immediately went with the Day Hab Team Leader to the Service Recipient's room to evaluate the concern, whereupon, she observed that the Service Recipient had also moved her bowels. Under the circumstances, the Subject was unable to assess whether the smell of the Service Recipient's urine portended a medical problem and she instructed the Day Hab Team Leader to notify nursing if the Service Recipient urinated again. Thereafter, the Subject received no further reports regarding the smell of the Service Recipient's urine. The Subject did not make any written record of the report of abnormally smelling urine, nor did she communicate it verbally to any other facility staff. (Hearing testimony of the Subject)

9. On the morning of [redacted], it was observed that the Service Recipient had a high fever through the previous night and, as an infection was suspected, she was transported to

a local hospital emergency department. The Service Recipient was diagnosed with a urinary tract infection, admitted to the hospital and treated with intravenous antibiotics and fluids. (Justice Center Exhibit 10 and Hearing testimony of facility Quality Improvement Specialist [redacted])

## 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 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.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2, 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.

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 established by a preponderance of the evidence that the Subject committed the act of neglect described in Allegation 1 of the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-32) The investigation underlying the substantiated report was conducted by facility Quality Improvement Specialist [redacted].

The Subject testified at the hearing in her own behalf and provided no other evidence.

A finding of neglect requires that a preponderance of the evidence establishes that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty and that the 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))

The Justice Center's argument was that, upon being advised that the Service Recipient's urine had an unusually strong smell, the Subject, as a facility RN, had a duty to communicate the concern to other medical staff and to make a written record of it, which she breached, and that the Subject's breach of duty delayed an earlier diagnosis of the Service Recipient's urinary tract infection, which ultimately resulted in the Service Recipient's avoidable hospitalization.

The Justice Center's evidence included numerous statements of facility staff confirming that, at the relevant time, the Service Recipient's urine had an unusually strong smell. (Justice Center Exhibits 6, 21, 22, 23 and 29). However, the Justice Center's evidence regarding how the concern was reported to nursing in general, and the Subject in particular, was far less certain. In any case, the Subject testified that she was advised of the concern on one occasion, when the Day Hab Team Leader reported it to her directly. The Subject's testimony in this regard is accepted as fact.

Counsel for the Subject argued that the Subject had been notified of the concern regarding the odor of the Service Recipient's urine on Tuesday, [redacted], and not Monday, [redacted], as alleged, the implication being that the allegation as strictly stated was inaccurate and therefore, technically untrue. The Subject testified that it was on Tuesday, [redacted], and not Monday, [redacted], that the Day Hab Team Leader approached the nursing office and advised her that the Service Recipient's urine had an unusually strong odor. The Day Hab Team Leader recalled (Justice Center Exhibits 21 and 22) having told the Subject of her concern on Monday, [redacted]. LPN 2 corroborated the date in her statement (Justice Center Exhibit 27) stating that she remembered that it was on Monday, [redacted], that the Day Hab Team Leader came to the nursing office near the shift change time and told the Subject that the Service Recipient's urine smelled unusual, and that the conversation occurred while she was dispensing medication and while the Subject was doing the charting and treatments. Furthermore, while the

Day Hab Toileting Chart (Justice Center Exhibit 8) does not specify the Subject's name, it is apparent from the note in the margin that the concern first arose with the Day Hab staff on Monday, [redacted]. Accordingly, it is found that it was on Monday, [redacted], as alleged, that the Subject was notified of the unusual smell of the Service Recipient's urine.

The other facts in this case are not in dispute. The evidence that the Day Hab Team Leader had reported the concern regarding the Service Recipient's urine specifically to the Subject came solely from the Subject's admissions in her statement (Justice Center Exhibit 25) and in her hearing testimony. The Subject also admitted that, after not being able to assess the Service Recipient's urine, she took no further steps regarding the concern.

The Subject testified that, under the circumstances, she acted appropriately. The Subject testified that, at that time, she attempted to evaluate the Service Recipient's urine, but was unable to do so then because the Service Recipient had also defecated, the odor of which eclipsed the urine's smell; that she examined the urine, nonetheless, and found it to look normal and that she instructed the Day Hab Team Leader to notify her if the Service Recipient urinated again. The Subject testified that she did not hear back from the Day Hab Team Leader that day or at any other time and that no one else reported any related concern to her at any relevant time either. The Subject testified that she worked from [redacted] until [redacted], and that none of the nursing notes from any of the shifts on those dates contained a record of any complaint by the Service Recipient or any mention of the odor of her urine. The Subject testified that the Service Recipient's vital signs for those dates were within "normal limits" and that generally, when there is a urinary tract infection, other symptoms emerge, such as behavioral changes, pain and frequency of urination, which were not noted in this case. The Subject testified that although the Day Hab Toileting Chart (Justice Center Exhibit 8) mentions that the Service Recipient's urine smelled abnormal, it was not a record that she was responsible for reviewing, or that she had ever

seen before. The Subject testified that she did not make a written record of the Day Hab Team Leader's concern regarding the unusual smell of the Service Recipient's urine, nor did she communicate the issue to any other medical staff, because she had seen nothing abnormal or concerning.

Regarding the Subject's duty, the email (Justice Center Exhibit 16) from Registered Nurse 1 (RN 1) dated [redacted] indicates that, while no formal procedure had been presented to the facility nurses regarding the documentation of reported medical concerns, it was best nursing practice and typical at the facility to look into and document, either in the nursing notes or shift turnover log, all concerns reported by other staff regarding the service recipients. Whether or not it was the basis of a formal training, common sense dictates that, in a facility designed for special needs individuals with increased medical requirements, the Subject, as a RN, would not only attempt to assess the Service Recipient's condition upon receiving a report of a concern, but also would communicate the concern to other medical staff verbally and by documentation to create an awareness among the other nurses of the issue. Accordingly, it is found that the Subject breached her duty to the Service Recipient by failing to communicate to the nursing staff the medical concern reported to her by the Day Hab Team Leader.

Having determined that the Subject breached her 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. RN 3 indicated in her email to RN 1 (Justice Center Exhibit 6) that, had the other nurses been made aware of the report that the Service Recipient's urine was abnormal, her urine and temperature would have been monitored, other measures would have been taken and the Service Recipient's hospitalization could have been avoided. In fact, the Service Recipient's condition was not assessed until she developed a high fever and had to be hospitalized, which certainly

constituted a serious impairment of her physical, mental and emotional condition.

Accordingly, the report will remain substantiated with respect to the neglect allegation and the next issue to be determined is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. The facility was specifically for service recipients with increased medical needs and the Service Recipient had complicated diagnoses with numerous preexisting conditions. The Subject's failure to note the Team Leader's concern about the Service Recipient or to otherwise communicate it to the other facility medical staff certainly contributed to the delay in the diagnosis of the Service Recipient's urinary tract infection, which ultimately resulted in the Service Recipient's avoidable hospitalization. The Subject's conduct did seriously endanger the health, safety and welfare of the Service Recipient. 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 2 act.

Category 2 conduct under this paragraph shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that the 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], of neglect by the Subject of a Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report of neglect is properly categorized as a Category 2 act.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

**DATED**: October 18, 2018
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge