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, of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: January 16, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Thomas C. Parisi, Esq.
Ronald G. Dunn, Esq.
[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: Elizabeth M. Devane
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
401 State Street
Schenectady, New York 12305
Concluded: [redacted]

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.

[redacted]
By: Ronald G. Dunn, Esq.
Gleason, Dunn, Walsh & O'Shea
40 Beaver Street
Albany, New York 12207

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 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 [redacted], at the [redacted], located at [redacted], while a custodian, you committed neglect when you failed provide adequate medical care for a service recipient upon learning that his blood sugar level was dangerously high.

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, the [redacted], located at [redacted], provides medical services to individuals with developmental disabilities 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 [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6 and 27, ALJ Exhibit AA)

5. At the time of the alleged neglect, the Service Recipient was a thirty-six-year-old male with diagnoses including mild intellectual disability, personality disorder and schizoaffective disorder bipolar type. His medical history included deep vein thrombosis, necessitating treatment with Coumadin, and a chronic stasis leg ulcer. Due to these conditions, the Service Recipient was seen routinely at the facility for testing to monitor how long it took his blood to clot and to monitor his leg ulcer. The Service Recipient also had his annual physical exam at the facility. (Hearing testimony of Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 11, 12, 13, 17, 18, 24 and 27; ALJ Exhibits AA, CC, DD, FF, GG and KK)

6. At the time of the alleged neglect, the Subject had been employed as a Medical Specialist 2 at the facility for approximately five years. His normal hours were [redacted] Monday through Friday. The Subject was an osteopathic physician, residency trained and board certified in family practice. The Subject's duties included providing medical care and treatment to service recipients. Specifically, the Subject performed physical examinations; made referrals; ordered and reviewed medical tests, medications and records; explained health conditions; coordinated treatment and provided medical advice. The Subject was current on all OPWDD required training and had signed the code of conduct pledge to prevent abuse, neglect or harm toward any person with special needs. The facility used a team approach, which meant that all of the patients/service recipients were the responsibility of all of the doctors. The Subject was a custodian as that term is defined in Social Services Law § 488(2). (Hearing testimony of Justice

Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 13, 19, 22 and 27; ALJ Exhibits AA, CC, DD, GG and KK)

7. On the morning of [redacted], the Service Recipient's blood was drawn for testing at the [redacted] Hospital Laboratory (Lab) pursuant to a written prescription from the facility and in anticipation of his yearly physical examination which was scheduled for [redacted]. (Hearing testimony of Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 11, 12, 13, 17, 18, 24 and 27; Subject Exhibit A; ALJ Exhibits FF and JJ)

8. On [redacted], the Subject left the facility for the day at 1:00 p.m. to travel to Canada for a concert. (Hearing testimony of Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6 and 27; ALJ Exhibits AA, CC)

9. It was the protocol of the Lab to orally notify the physician, whose name was indicated on the prescription, when the result of ordered lab work indicated a critical level needing prompt attention. (Hearing testimony of Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 8, 9, 10 and 27; Subject's Exhibit A; ALJ Exhibits AA, CC, DD, GG, JJ and KK)

10. At about 1:00 p.m. on [redacted], the Medical Technologist (hereinafter referred to as [redacted]) at the Lab was notified that the Service Recipient's blood work results indicated a glucose level of 645 mg/dl which was considered a critically high value, capable of negative consequences, and required immediate attention. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 6, 7, 11, 12, 13, 17, 18, 24 and 27; ALJ Exhibits AA, DD, FF, GG, JJ and KK)

11. On [redacted], at approximately 1:12 p.m., [redacted] called the telephone

number [redacted] and reported to the male who answered the call and stated that he was [redacted], that the Service Recipient's blood work was returned with the critical glucose value of 645 mg/dl. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 6, 8, 9 and 27; ALJ Exhibit JJ)

12. On [redacted], the Subject performed the Service Recipient's annual physical. The physical exam report indicated that the Service Recipient had an uneventful medical year other than his chronic stasis leg ulcer. A notation on the plan section of the physical exam report indicated that the annual labs were just done and to obtain the results. (Hearing testimony of Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 11, 12, 13, 16 and 27; ALJ Exhibits AA, DD and EE)

13. On [redacted], the Service Recipient was taken to the facility by staff at his residence as he indicated that he was not feeling well. The Service Recipient told the facility Registered Nurse (RN) that he was dizzy, "foggy in the head" (Justice Center Exhibit 13), he had belly cramps and reported excessive thirst and a reduced appetite. The RN checked the Service Recipient's blood sugar level. The result indicated a glucose level that was greater than 600 mg/dl, the highest level that the facility glucometer tested to, which was considered a critically high glucose value. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 6, 13, 16 and 27; ALJ Exhibits DD, GG and II)

14. The facility RN reported that glucose result to a facility physician (Dr. 1) who had the Service Recipient be taken by ambulance to the [redacted] Hospital Emergency Room. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 6, 13, 16 and 27; ALJ Exhibits DD and GG)

15. At [redacted] Hospital, the Service Recipient was diagnosed with diabetic

hyperglycemia and new onset diabetes mellitus. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 6, 13, 16 and 27; ALJ Exhibits FF and GG)

16. The Service Recipient was examined at the facility the next day, [redacted], following the Emergency Room visit. New medications, including metformin, Amaryl and Lantus insulin, were ordered. In addition, dietary changes were implemented and a diary of daily glucose monitoring commenced. On [redacted] and [redacted], staff at the Service Recipient's residence were trained regarding administration of the medications and changes to the Service Recipient's plan. (Hearing testimony of Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 13, 14, 15, 16 24 and 27; ALJ Exhibit FF)

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 neglect.
- Pursuant to Social Services Law § 493(4), the category of 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 SSL § 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. 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, which is defined as:

> (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 proved by a preponderance of the evidence that the Subject committed neglect as described in "Allegation 1" in the substantiated reports.

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 he breached that duty, and that his 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 – 22, 24 and 26) and a disc containing audio recordings of Justice Center interviews (Justice Center Exhibit 27). Subsequent to the hearing and with the assent of the Subject, the Justice Center submitted transcripts of the audio recordings. (ALJ Exhibits AA – LL) 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 Subject testified in his own behalf and presented two exhibits (Subject Exhibits A and B).

The issue to be determined, aside from analyzing the numerous arguments presented, is whether the Subject received a telephone call on [redacted] from [redacted] Laboratory (Lab) reporting the result of the Service Recipient's lab work which indicated that he had a critical blood

glucose level and, if the Subject did receive that telephone call, whether the Subject breached his duty by failing to provide adequate medical care for the service recipient upon learning that his blood sugar level was dangerously high.

The Subject stated that he did not receive the alleged telephone call from the Lab regarding the Service Recipient. The Subject further argued that, even if he had received such a call, he was not on duty and was therefore not responsible for patient care, ostensibly claiming he was not a custodian at that point. The Subject indicated if he had received such a call, his response would have been to tell the Lab to call the facility. (Hearing testimony of the Subject; Justice Center Exhibit 27; ALJ Exhibit CC)

The Subject was employed as a physician at the facility with the title of Medical Specialist 2. The facility used a team approach and all the physicians were responsible for the overall care of all the service recipients in their care. The Subject knew the Service Recipient from past encounters at the facility. If a physician receives notification of a critical value regarding a patient, even if he or she is not in the office or on call, it is their duty to take action on that report. Being off duty does not relieve the Subject from his custodial duties under these circumstances. (ALJ Exhibits AA, DD, GG and KK) Any argument that the Subject was not a custodian or not responsible for care of the Service Recipient at the time of the alleged call fails. (Hearing testimony of Justice Center Investigator [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 8, 9, 11, 12, 13, 16, 19, 22 and 27; ALJ Exhibits AA, DD, FF, GG, JJ and KK)

The Justice Center argued that the Subject did in fact receive the telephone call from the Lab disclosing the Service Recipient's critical glucose value and that the Subject breached his duty by failing to provide adequate medical care for the Service Recipient upon learning that his blood

sugar level was dangerously high.

[redacted] stated in his [redacted] interview with the Justice Center that, after he discovered the critical level of the Service Recipient's blood glucose on [redacted], he found the Subject's telephone number in the Lab's records to report the information as Lab protocol directed. [redacted] stated that he called the telephone number on file and reached the [redacted] Clinic. [redacted] stated that he was told by the [redacted] Clinic that the Subject was no longer employed there; however, the [redacted] Clinic gave [redacted] the telephone number where the Subject could be reached, [redacted]. When [redacted] dialed telephone number [redacted], a male answered the call, identified himself by the Subject's name, appeared surprised and asked where [redacted] had gotten his telephone number. [redacted] then reported to the Subject that the Service Recipient's blood work had returned and indicated a critical blood glucose value of 645 mg/dl. [redacted] reported that the telephone call lasted no more than a minute or so. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 6 and 27; ALJ Exhibit JJ)

[redacted] stated in his [redacted] written statement, that when he received the lab report that indicated the Service Recipient's critical blood glucose level, he followed Lab policy and located the contact information for the person listed on the prescription, which was the Subject. [redacted] stated that he called that telephone number, which was the [redacted] Clinic, was told by the [redacted] Clinic the Subject was no employed longer there and was given a contact number of [redacted] for the Subject. [redacted] wrote that when he called the telephone number that he was given, at 1:12 p.m., a male who said he was the Subject answered the phone, appeared annoyed, and asked how [redacted] got the number. [redacted] stated that he told the Subject that the Service Recipient had a critical glucose value of 645, the Subject said ok, thank you and the call ended. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 6 and 8)

The [redacted] Lab report indicates the results of the Service Recipient's blood work and, in the middle of the page, the blood glucose value of 645 mg/dl is reported. Recorded onto the report and typed directly under that result, it states "CALLED TO AND READ BACK BY [redacted] AT 112PM BY [redacted]". (Justice Center Exhibit 9) The Investigator testified that [redacted] made that notation on the report on [redacted]. The Lab sent a paper copy of that report, improperly to [redacted], on [redacted] and [redacted] subsequently forwarded that report to the facility, on or about [redacted].

The record includes a page of the Subject's Verizon Wireless telephone records from cell number [redacted] containing information from [redacted]. (Justice Center Exhibit 10) The sixth line down on the exhibit indicated: Dialed Digit Number, [redacted]; Seizure Dt Tm, [redacted] 13:10; Seizure Duration, 56; and Calling Party Number [redacted]. The Investigator testified that the record shows [redacted] called the Subject at 1:10 p.m. on [redacted] from the Lab number, [redacted], and that the call lasted for 56 seconds. However, she was not certain of the meaning of the terminology contained in the exhibit and the record lacked evidence to sufficiently explain the information contained in the exhibit. (Hearing testimony of Investigator [redacted]; Justice Center Exhibits 6 and 10)

The Subject stated unequivocally that he never received a call from [redacted] on [redacted]. The Subject posited a number of arguments: that [redacted] did not place the call; [redacted] placed the call, but at the time the Subject was in his car and in an area where the cellphone service was spotty; that [redacted] may have called and left a voicemail but the Subject never received it; that [redacted] placed the call but never received acknowledgment from the Subject that he actually heard the critical glucose reading; that [redacted] statements were inconsistent; and that [redacted] should have called the clinic or the person who signed the prescription. The Subject stated during his first interview that

he suspected that there was a personal vendetta against him which was the root of the investigation. The Subject argued that [redacted] feared for his own job and that the Lab was attempting to cover up the many mistakes that it made, citing the confusion surrounding where and when the results were sent.

In an effort to bolster his arguments, the Subject testified at the hearing and stated during his [redacted] interrogation, that he did an experiment in which he had his wife call him twelve minutes after he left the facility. He said his wife left him a voicemail, that the call never showed up on his phone "no call and no voicemail", (Justice Center Exhibit 27; ALJ Exhibit CC) but that he later looked at his Verizon records online and the records indicated that his wife had called him. (Justice Center Exhibit 27; ALJ Exhibit CC) The date, time and location of the parties involved surrounding any such call are not in the record. The Subject also introduced a letter dated [redacted] with the clinic director's name on the bottom stating "I had [redacted] drive 15 minutes from the clinic today, called him twice, then checked his phone on return; my calls were not recorded. It is unlikely that the lab tech was able to leave a message for [redacted] to warn him of the high blood sugar." (Subject Exhibit B)

The Subject stated that his name was inappropriately noted as the Service Recipient's physician on the prescription for the blood tests and that because the Nurse Practitioner (NP) signed the prescription, the Lab should have called the NP. (Subject's Exhibit A) The NP stated she often signs prescriptions at the facility and that, while she usually checks off her name, if the Subject's name was already checked she might not have noticed it. The NP stated that it was common practice that the name of the physician scheduled to attend to a service recipient for a physical was checked off on such a prescription. (Justice Center Exhibit 27; ALJ Exhibit KK) Regardless, the Subject's name was checked at the top of the prescription, and the Subject was the

party who [redacted] stated he eventually reported the critical value to on [redacted].

The two statements by [redacted] were consistent in all important respects and are credited evidence. (Justice Center Exhibits 8 and 27; ALJ's Exhibit JJ) The Subject's arguments that [redacted] did not receive acknowledgement from the Subject that he actually heard the report and/or that [redacted] statements were inconsistent regarding how the call ended were considered and, after a review of the statements and record, hold no weight. Based on the lack of definitive information, the cell phone record is inconclusive. (Testimony of Justice Center Investigator [redacted]; Justice Center Exhibit 10) [redacted] stated that he "absolutely" (ALJ Exhibit JJ, p. 6) did not leave the information on a voicemail. [redacted] typed "CALLED TO AND READ BACK BY [redacted] AT 112PM BY [redacted]" on the report. (Justice Center Exhibit 9) That information was entered onto the report before anyone, apparently other than the Subject, was aware that there was an issue surrounding any lack of action based on the report of the critical value. (Hearing testimony of Justice Center Investigator [redacted]) The experiment reportedly done by the Subject's wife at some point and the letter purportedly from the clinic director have no established reliability and are not credited evidence. (Hearing testimony of the Subject; Subject's Exhibit B; Justice Center Exhibit 27; ALJ's Exhibit CC) Even if they were deemed credible as to what they purport, they are not indicative of anything regarding the call in question.

After a full review of the evidence and the Subject's demeanor and testimony, it is determined that the Subject's version of events is not credited evidence. The statements of [redacted] contained in the record are credited evidence. The Subject is determined to have received the call and the information from [redacted] reporting the Service Recipient's critical blood glucose level.

The next question is whether the Subject breached his duty by failing to provide adequate medical care for the Service Recipient upon learning that the Service Recipient's blood sugar level

was dangerously high. Dr. 1 stated that if a physician receives notification of a concerning value regarding a patient, even if the physician was not in the office or on call, it was "definitely" (ALJ Exhibit GG, p. 9) the responsibility of the physician to take action. When Dr. 1 was notified of the Service Recipient's blood glucose level of over 600 mg/dl on [redacted], Dr. 1 sent the Service Recipient to the [redacted] Hospital Emergency Room. Dr. 1 explained that a blood glucose level that high was "very unusual" (ALJ's Exhibit GG, p. 22) and indicated hyperglycemia which is a condition that can get patients "into trouble" (ALJ's Exhibit, GG p. 21). Dr. 1 stated that the matter was "an emergency" (ALJ's Exhibit, GG p. 28) and could not be treated at the facility as IV fluids and IV insulin needed to be administered and therefore had the Service Recipient go to the Emergency Room. (ALJ Exhibit, GG p. 35) The facility RN stated that it was common practice for labs to call when blood work of a service recipient indicated a critical level and when a physician is informed of a critical level, it is that physician's responsibility to act on that. (ALJ Exhibit DD) The facility NP agreed that a glucose level over 600 is a critical value and stated that when there was a critical value "immediate action should always be taken" (ALJ Exhibit KK, p. 14) The Subject himself, when first interviewed on [redacted] stated that a 645 glucose value is very high (ALJ Exhibit AA, p. 13) and that such a value requires action (ALJ Exhibit AA, p. 21). If a physician receives notification of a critical value regarding a patient, even if he or she is not in the office or on call, it is their duty to take action and provide adequate medical care.

When asked by the Investigator during that first interview what he would have done had he received the call in question, the Subject stated, "I would have had to call the clinic back and let them know there was an abnormal…critical." (Justice Center Exhibit 27; ALJ Exhibit AA, p. 28) This differs from the Subject's response to the same question when interrogated on [redacted] in which the Subject stated "If I received the phone call and spoke to the person, I would tell

them that I was no longer on duty at the clinic. That the clinic was still open. And they needed to contact the clinic." (ALJ Exhibit CC, p. 12) The Subject testified in the hearing that the proper response to receiving a notification of a critical value from a lab would be to make a notification of some kind. The Subject agreed that part of his job was to make sure that someone would be notified of the critical level. (Hearing testimony of the Subject) The Subject's three statements are inconsistent and are not credited evidence.

The weight of the credible evidence in the record supports a finding by a preponderance of the evidence that the Subject breached his duty by failing to act and provide adequate medical care for the Service Recipient upon learning that his blood sugar level was dangerously high.

The Subject's breach resulted in, or was likely to have resulted in, serious or protracted impairment of the Service Recipient's physical condition. The Subject took no action when notified of the Service Recipient's critical blood glucose level on [redacted]. The Service Recipient received no treatment for his dangerously high blood glucose level until he went to the facility, as he was ill, on [redacted] and was tested, and sent to the Emergency Room. At the hospital, the Service Recipient was diagnosed with and treated for diabetic hyperglycemia and new onset diabetes mellitus. He was prescribed medication, dietary changes were made and daily glucose monitoring was commenced. (Hearing testimony of Justice Center Investigator [redacted]; Justice Center Exhibits 6, 13, 16 and 27; ALJ Exhibits DD, FF, GG and II) The Subject's failure to act upon being notified of the Service Recipient's dangerously high blood sugar level by the Lab caused a delay in the Service Recipient's diagnoses and treatment. Consequently, the Subject's conduct resulted in or was likely to have resulted in, serious and/or protracted impairment of the Service Recipient's physical condition.

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. 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. The report was substantiated as Category 2 neglect. To prove Category 2 conduct, the Justice Center must establish that the Subject's conduct "seriously endanger[ed] the health, safety or welfare of [the] service recipient …" (SSL § 493(4)(b)) by committing the act of neglect. The Subject admitted that a glucose level of 645mg/dl was very high and that a level that high could mean "certainly diabetes… you worry about, you know, patients having a diabetic coma, having an increased acetone level, you know, that type of thing" (ALJ Exhibit AA, p. 13) Information from [redacted] Hospital states, "Over time, uncontrolled diabetes can damage your nerves, blood vessels, tissues, and organs. That is why it is important to manage diabetic hyperglycemia. Without treatment, diabetic hyperglycemia can lead to diabetic ketoacidosis (DKA) or hyperglycemic hyperosmolar state (HHS). These are serious conditions that can become life-threatening." (Justice Center Exhibit 13)

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.

A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. 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] 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 2 act.

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: January 9, 2018
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge