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 28, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Jennifer McGrath, Esq.
[redacted], Subject, Pro se

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

Parties: New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Jennifer McGrath, Esq.

[redacted]

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 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 substantiated the report against the Subject concluding that:

Allegation 2[1]

> It was alleged that on [redacted], at the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide adequate medical care by not contacting the nurse after you discovered medical concerns regarding a service recipient.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

4. The facility, the [redacted], located at [redacted], is a residence for people with developmental disabilities. The IRA is operated by [redacted], which is certified by the New

[1] Allegation 1 was unsubstantiated before the hearing.

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))

5. At the time of the alleged neglect, the Subject was employed part-time by [redacted] as a Residential Habilitator (RH) and was certified as an Approved Medication Administration Personnel (AMAP). (Hearing testimony of the Subject) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the male Service Recipient was seventy-one years old, and had been a resident of the facility for approximately three years. The Service Recipient had relevant diagnoses of cerebral palsy, osteoporosis and seizure disorder, and a history of bilateral femur fractures. (Justice Center Exhibits 11 and 14, and Hearing testimony of the Investigator) The Service Recipient was confined to a wheelchair and had limited use of his hands and arms. (Hearing testimony of the Subject)

7. The Service Recipient had a Plan of Nursing Services (PONS) for osteoporosis, which indicated that the Service Recipient's bones were very brittle, easily fractured and that fractures may occur "spontaneously." In pertinent part, the PONS dictated that facility staff were required to "inform RN if [the Service Recipient] complains suddenly of severe back pain or pain in any extremity and document in HRPN." (Justice Center Exhibit 11) The Service Recipient did not always express when he was in pain. (Justice Center Exhibit 14, p.18) The Subject was familiar with the contents of the PONS. (Hearing testimony of the Subject)

8. On [redacted], facility overnight shift Direct Support Professional (DSP) [redacted] (Staff 1) noticed a bump on the front of the Service Recipient's right knee/leg area. After conducting a body check and telephoning the nurse, he documented his finding in the Health

Related Progress Notes. (HRPN). (Justice Center Exhibits 7 and 22: audio recording of Justice Center interview of Staff 1)

9. On [redacted], when morning shift DSP [redacted] (Staff 2) was fixing the Service Recipient's right sock, the Service Recipient "said ouch and flinched." When Staff 2 moved the Service Recipient's right hip, he flinched again. Staff 2 documented this in the HRPN and telephoned [redacted], the facility Registered Nurse (RN) who later assessed the Service Recipient and found no bruising or swelling. (Justice Center Exhibit 7 and Hearing testimony of the Investigator)

10. After [redacted], the Service Recipient continued to have pain which was documented by facility staff in the communication log and in the HRPN. The RN was aware of the Service Recipient's pain but concluded that, because the pain was relieved by the administration of Tylenol, it was not necessary for the Service Recipient to be evaluated at the hospital. (Justice Center Exhibit 22: audio recording of Justice Center interview of the RN; and Hearing testimony of the Investigator)

11. The RN was off work [redacted], [redacted], [redacted], [redacted] and [redacted]. (Justice Center Exhibits 15 and 17, and Hearing testimony of the Investigator)

12. The facility provided an on-call nursing service Monday through Friday during the overnight hours from 5:00 p.m. to 8:00 a.m. and all day on weekends and holidays. (Justice Center Exhibit 10 and Hearing testimony of the Subject) In the month of [redacted], there were no telephone calls placed by the facility to the "on-call" nursing service. (Justice Center Exhibit 23 and Hearing testimony of the Investigator)

13. It was the usual and regular practice of facility staff to make a short general entry in the communication log, which triggered the duty, of any facility staff reading the

communication log, to then review the HRPN for details. (Hearing testimony of [redacted] (Staff A)

14. On [redacted], the Subject was assigned primarily to the care of the Service Recipient, with the focus on bathing, toileting and feeding him. Additionally, the Subject was responsible for medication administration for all service recipients in the facility. At approximately 8:00 a.m., while the Subject was assisting the Service Recipient with putting his shoes on, the Service Recipient said: "It hurts." The Subject asked him what part of him hurt and the Service Recipient responded that his leg hurt. The Subject then provided him with Tylenol which, after taking it, relieved his pain. (Justice Center Exhibits 9 and 22: audio recording of Justice Center interrogation of the Subject; and Hearing testimony of the Subject)

15. The Subject documented the Service Recipient's pain and the administration of Tylenol in the HRPN and the communication log. (Justice Center Exhibits 5 and 7) The Subject did not attempt to contact the on-call nursing service because it was after 8:00 a.m. and outside the hours of the service. Instead, the Subject waited to inform the RN when she arrived for the day. When the RN did not arrive, the Subject contacted [redacted], the house manager (Manager) who informed the Subject that the RN was not working that day. The Subject then reported to the Manager the Service Recipient's pain and the administration of Tylenol, and opined that the Service Recipient should go to the hospital due to his leg pain recurring for several weeks. The Manager responded, "okay," told the Subject nothing else and took no further action. (Hearing testimony of the Subject)

16. On [redacted], the facility Director reviewed the HRPN, specifically the Subject's [redacted] entry regarding the Service Recipient's leg pain and the administration of Tylenol and made the decision to have the Service Recipient evaluated at the hospital for his cough and continued leg pain. (Hearing testimony of the Subject) The Service Recipient was

evaluated at the hospital that day and diagnosed with a hair line fracture of the right leg. (Hearing testimony of the Justice Center Investigator)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL §§ 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of 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 3, which is defined as follows:

> (c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of neglect alleged in the substantiated report that is the subject of the proceeding and that such act or 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 act of neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

If the Justice Center did not prove the neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that Subject [redacted] committed the act, described as "Allegation 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation that were admitted into evidence. (Justice Center Exhibits 1A through 15, 17 through 21, and 23) The Justice Center also presented audio recordings of the

Investigator's interview of witnesses and interrogation of the Subject. (Justice Center Exhibit 22) The investigation underlying the substantiated report was conducted by the Investigator, who was the only person who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented no other evidence. [redacted] (Staff 3) also testified.

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject's 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 Recipient. (SSL § 488(1)(h))

The Justice Center contends that the Subject breached her duty to provide adequate medical care to the Service Recipient on [redacted], by failing to contact the RN after the Service Recipient complained to the Subject of pain by saying "It hurts", and that the Subject's breach of duty resulted in or was likely to result in physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional condition.

The Subject argued that she did not contact the RN because the RN was off work that day and not available and that, because it was not within the hours covered by the on-call service, she did the only thing that she could have done: she informed the Manager of the Service Recipient's complaint of pain.

The Subject testified that she documented the Service Recipient's complaint of pain in the HRPN and the communications log, then waited for the RN to arrive at the IRA to report the Service Recipient's exclamation of pain to the RN. She further testified that, because the RN did not arrive and it was outside the hours covered by the on-call nursing service, she informed the Manager of the Service Recipient's complaint and her inability to contact a nurse. The Subject

further testified that the Manager offered her no advice and gave her no further instructions. (Hearing testimony of the Subject)

When interviewed by the Justice Center Investigator, the Manager denied that the Subject advised her of the situation on [redacted]. (Justice Center Exhibit 22: audio recording of Justice Center interview of the Manager) However, after observing and evaluating the hearing testimony of the Subject on this issue, and weighing the Subject's testimony against the Manager's statements, the Administrative Law Judge presiding over the hearing finds the Subject's testimony to be credible and, consequently, the Manager's statements are not credited evidence.

The record reflects that facility policy provided an alternative to the facility RN for nursing services during off-hours. However, it did not provide an alternative for nursing services during regular hours when the RN was not available, such as when the RN was on vacation or otherwise not at work. This gap in facility protocol left facility staff without direction or the ability to follow the facility policy (the PONS) that required staff to inform the RN when the Service Recipient complained of pain in his extremity.

Given this gap in policy, the Subject acted in a reasonable manner by documenting the Service Recipient's complaint of pain in the communications log and HRPN, and by advising the Manager, her immediate supervisor, of the situation. Consequently, the Subject cannot be found to have breached her duty to provide adequate medical care to the Service Recipient on [redacted], by failing to inform the RN when she had no means of doing so.

The Justice Center argues that, because the Subject opined to the Manager that the Service Recipient should be taken to the hospital, she had a duty to telephone 911. The facility policy for contacting the on-call nursing service includes a provision that: "if while waiting for a response from the RN and you feel the consumer's condition is becoming life threating, STOP and call 911!" (emphasis in the original). (Justice Center Exhibit 10)

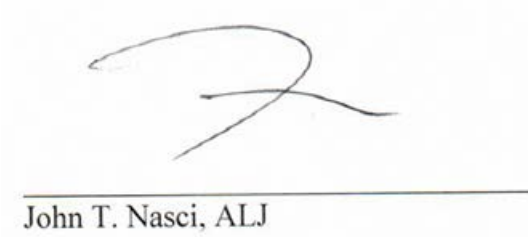
While the Subject testified that she believed that the Service Recipient should be evaluated because of the recurring complaints of pain, there is no evidence in the record that the Subject believed that the situation had become life threatening. Consequently, the Subject did not have a duty to telephone 911 and activate emergency services on [redacted].

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

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

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

DATED: January 23, 2019
Schenectady, New York



John T. Nasci, ALJ