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

| | |
|---|---|
| In the Matter of the Appeal of<br>[redacted]<br>Pursuant to § 494 of the Social Services Law | **FINAL DETERMINATION AND ORDER AFTER HEARING**<br>**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 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 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 by [redacted] as a Direct Support Professional (DSP) and had been employed by the facility for approximately six months. The Subject was certified as an Approved Medication Administration Personnel (AMAP) in [redacted], just prior to the date of the alleged neglect. (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 [redacted] (Staff A))

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 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. On [redacted], the Subject was assigned to medication administration for the first time as facility staff. On that day, the facility manager and the RN informed the Subject that the two of them had lifted and rotated the hip of the Service Recipient and that they determined that the Service Recipient did not have a fracture. The RN further stated to the Subject that, in her opinion, the Service Recipient was prone to inflammation that resulted in pain at his hip joint during colder months, and that the raised bumpy area on his hip was the result of a previous break healing. (Hearing testimony of the Subject)

12. On [redacted], the Subject was assigned primarily to the care of a service recipient other than the Service Recipient, and was generally assigned to medication administration for all service recipients. Because it was the Subject's second day of medication administration,

she was assisted by a [redacted] (Staff 3), a more senior employee. At approximately 10:00 p.m., as the Subject approached the Service Recipient who was lying in bed, the Service Recipient said "Ow, ow, ow." The Subject told the Service Recipient that she was going to apply some cream to the eczema on the skin near his heel. When the Subject lifted the Service Recipient's thigh and hip to obtain access to his heel, the Service Recipient said "Ouch", but he did not flinch or move when she applied the cream. When the Subject told Staff 3 that the Service Recipient said "Ow," Staff 3 told her that the Service Recipient had recently received a Tylenol for pain and advised her to document her findings in the HRPN and the communication log book. The Subject made the entries as directed but she did not notify the RN. (Justice Center Exhibits 7, 9 and 22: audio recording of Justice Center interrogation of the Subject; and Hearing testimony of the Investigator)

13. The usual and regular practice at the facility was for 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 the Subject)

14. On [redacted], the facility Director reviewed the HRPN, specifically a [redacted] entry made by Staff A regarding the Service Recipient's leg pain and Staff A's 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 Staff A) 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 established by a preponderance of the evidence that the Subject committed the acts, 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 1B through 15, 17 through 21, and 23) The Justice Center also presented audio recordings of the Justice Center 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. Staff A 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 Recipients. (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 inform the RN after the Service Recipient complained to the Subject of pain by saying "Ouch", 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, although the Service Recipient complained by saying "Ouch," when she started to move his leg in order to apply cream to his foot, the Service Recipient did not flinch and was not in distress, therefore, it was not necessary to inform the RN. The Subject testified that she consulted with Staff 3, who was her senior staff for administering medication that day, and Staff 3 told her to document the Service Recipient's exclamation of pain in the HRPN. (Hearing testimony of the Subject) The Subject documented the Service Recipient's complaint of pain in the HRPN and also made a note on the communications log concerning the administration of the Service Recipient's cough medication. (Justice Center Exhibits 7 and 9) The Subject further argues that, by making an entry in the HRPN and the communications log, she indirectly informed the RN.

The Service Recipient's PONS required staff to "inform RN" if the Service Recipient "complains suddenly of … pain in any extremity and document in HPRN." (Justice Center Exhibit 11) The record reflects that the Service Recipient complained of pain in his extremity by saying "Ouch" when the Subject touched his leg. The PONS dictated that, upon hearing the Service Recipient's complaint, the Subject was required to inform the RN and document it in the HRPN. Although the Subject documented the complaint in the HPRN, she did not inform the RN.

The Subject's argument, that she was not required to inform the RN because the Service Recipient did not flinch and was not in distress, is without merit because the PONS did not mention these two conditions. It merely directed staff to inform the RN in the event that the Service Recipient complained of pain in an extremity. The Subject's argument, that she informed the RN indirectly by making an entry in the HRPN and the communications log, is also without merit. The PONS directs that staff both inform the RN and document the Service Recipient's pain in the HRPN, making a clear distinction between the two tasks and indicating that the two tasks are not equivalent to each other. The Subject had a duty to inform the RN upon hearing a complaint of pain from the Service Recipient but failed to do so, thereby breaching her duty.

Although the record reflects that the Service Recipient was diagnosed three days later with a hair line fracture of the right leg, there is insufficient evidence in the record to find that the fracture was a result of the Subject's conduct. However, because the Service Recipient's bones were so fragile that "fractures may spontaneously occur" (Justice Center Exhibit 11), it is found that the Subject's breach of duty was likely to result in physical injury or serious 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 or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act.

Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a

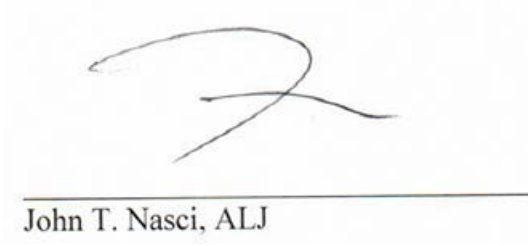
Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496 (2). The report will be sealed after five years.

**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 3 act.

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

**DATED**: January 23, 2019
Schenectady, New York



John T. Nasci, ALJ