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: November 16, 2020
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Todd Sardella, Esq.
Thomas Bortscheller
[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: Keely D. Parr
Administrative Law Judge

Held at: Video Conference Hearing
Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
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: Thomas Bortscheller
19 Manhattan Row
Averill Park, New York 12018

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 substantiated the report against the Subject. The Justice Center concluded that:

Allegation 1

It was alleged that on or about or between [redacted] and [redacted], while at [redacted], located at [redacted], you committed Neglect against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 1 Neglect pursuant to Social Services Law § 493(4)(a).

The investigation revealed the Subject failed to provide adequate and/or timely medical care to the service recipient.

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

4. The facility, located at [redacted], is an individual residential alternative (IRA) providing 24-hour care, operated by the [redacted]

[redacted] and certified by the Office for People With Developmental Disabilities (OPWDD), a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject was employed by [redacted] as a direct care staff since 2014 and was trained in the American Red Cross Adult First Aid/CPR/AED course in August 2014 and June 2016. This certification was valid for two years and in effect at the time of the alleged incident. (Justice Center Exhibits 20 and 36)

6. At the time of the alleged neglect, the Service Recipient was a nonverbal 59-year old female diagnosed with severe intellectual disability, cerebral palsy, autism, and epilepsy, with a history of seizures. The Service Recipient needed assistance with all activities and required 24-hour supervision. (Justice Center Exhibits 28, 29 and 31)

7. On [redacted], the Subject worked the [redacted] shift at the IRA. Upon arrival, Staff #1[1] informed the Subject that the Service Recipient was not acting right and he requested that they look in on her. The Subject observed the Service Recipient "laying sprawled out on the bed, arms out on both sides" and looked close because she could not see her chest move. The Service Recipient's breathing was staggered, and she was gasping for breath. The way the Service Recipient was laying "was alarming" because the Service Recipient was flat on her back and always slept upright. The Subject paged the on-call nurse[2] at 11:15 p.m. (Justice Center Exhibits 11, 13, 20 and 35; Subject Exhibit A)

8. The on-call nurse tried to call the house number, but it was busy. The Subject was speaking with the Service Recipient's brother[3] who stated that he was concerned about the Service Recipient because he thought she was not acting normal when he saw her earlier that day. He

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1 [redacted]
2 [redacted]
3 [redacted]

requested that the Subject call the house manager[4] and the nurse. The telephone call began at 11:16 p.m. and lasted 24 minutes. The Subject paged the on-call nurse at 11:41 p.m. At 11:43 p.m., the on-call nurse telephoned the house and spoke with the Subject. The Subject informed the on-call nurse that the Service Recipient was nonresponsive, cold to the touch, short of breath, very pale and had been gasping for air all day and that they were unable to get a blood pressure or temperature reading on the Service Recipient. The on-call nurse instructed the Subject to telephone 911 and the Subject told the on-call nurse that she would do so right away. (Justice Center Exhibits 11, 13, 20 and 37; Subject Exhibits A, B and C)

9. The Subject telephoned the house manager who was also her supervisor. The Subject's supervisor arrived at the IRA and after checking the Service Recipient, instructed the Subject to call the on-call nurse back. At 12:05 a.m., the Subject paged the on-call nurse. At 12:06 a.m., the on-call nurse called the house back and asked if the ambulance had arrived. The Subject informed the on-call nurse that she had not yet telephoned 911 because they were looking for staff coverage to come in. The on-call nurse instructed the Subject to telephone the ambulance right away because they did not need staff to go with the Service Recipient. The Subject told the on-call nurse that she would do so. (Justice Center Exhibits 11, 13 and 20; Subject Exhibits A, B and C)

10. The Subject telephoned 911 at 12:09:52 a.m. on [redacted]. The Subject stated: "I don't know why I didn't call 911 when the nurse said to call." (Justice Center Exhibits 9, 13 and 20)

11. The ambulance arrived at 12:20:42 a.m. The EMTs stated, "We could tell that the Pt. [Service Recipient] was in serious condition" and noted an "audible wheeze". The Service Recipient was transported to the [redacted] Hospital emergency room. The emergency room

[4] [redacted]

physician[5] stated that the Service Recipient was hypoxic with a low oxygen saturation level in route to the hospital; that she had altered vital signs, altered labs and was ultimately diagnosed with septic shock with multi organ failures. Her examination upon arrival at the hospital revealed that the Service Recipient's hands and feet were mottled and cool to the touch and that she was hypothermic with a body temperature of 88.5. The Service Recipient's laboratory results indicated acute renal failure and shock liver, along with respiratory acidosis and dehydration. The Service Recipient was admitted to the hospital and transferred to the intensive care unit. The Service Recipient was given broad spectrum antibiotics and fluid resuscitation. (Justice Center Exhibits 9, 14, 15, 31, 34 and 37)

12. On [redacted], the Service Recipient died of a massive intracranial hemorrhage. As per the emergency room physician, the sepsis caused an alteration in the Service Recipient's clotting pathways and the intracranial hemorrhage that developed was due to her inability to clot. The emergency room physician stated that the sooner the Service Recipient would have gotten to the emergency room, the better her ultimate chances were going to be. He additionally stated that any delay is a higher risk of death for sepsis. (Justice Center Exhibits 31, 34 and 37)

13. The American Red Cross Adult First Aid/CPR/AED training included directives that trouble breathing is an emergency condition requiring 911; unresponsiveness and trouble breathing are all signs of a life-threatening emergency and that life-threatening emergencies require a call to 911. (Justice Center Exhibits 20 and 36)

14. The telephone triage protocol of the [redacted] states that staff will be instructed that at any time they believe there is a life-threatening emergency they are to call 911 immediately. "They

[5] [redacted]

do not have to wait for permission from a nurse to do so." (Justice Center Exhibit 7)

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 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and 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 is defined by SSL § 488(1) as:

> (h) "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.
>
> Physical injury is defined by SSL § 488(6) as:
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> 6. "Physical injury" and "impairment of physical condition" shall mean any confirmed harm, hurt or damage resulting in a significant worsening or diminution of an individual's physical condition.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 1 which is defined as follows:

> (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:
>
> > (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either.

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

In support of its substantiated findings, the Justice Center presented a number of documents and audio and video interviews obtained during the investigation. (Justice Center Exhibits 1-37) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who testified at the hearing on behalf of the Justice Center. Lieutenant [redacted] of the [redacted] Police Department and [redacted] of the Justice Center also testified at the hearing on behalf of the Justice Center.

The Subject chose not to testify and presented Subject Exhibits A - C.

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report. Specifically, the evidence establishes that the Subject committed neglect.

In order 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 she breached that duty, and that her 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))

At the time of the alleged neglect, the Subject was employed as a direct care staff by [redacted] and was acting as a custodian as that term is defined in Social Services Law § 488(2). The Subject had a duty to follow the nurse's directive, the telephone triage protocol of the [redacted] and her training in American Red Cross Adult First Aid/CPR/AED and telephone 911 immediately. The Subject breached that duty by not telephoning 911 when she first observed the Service Recipient gasping for breath at approximately 11:15 p.m. and by not telephoning 911 when the on-call nurse first instructed her to do so at 11:43 p.m. The Subject did not telephone 911 until 12:09 a.m., almost

one hour after she observed the Service Recipient gasping for breath and 26 minutes after the nurse's directive instructing her to telephone 911. (Justice Center Exhibits 7, 9, 11, 13, 20 and 36; Subject Exhibits A and B)

On [redacted], the Subject worked the [redacted] shift at the IRA. Upon arrival, Staff #1 informed the Subject that the Service Recipient was not acting right and he requested that they look in on her. The Subject observed the Service Recipient "laying sprawled out on the bed, arms out on both sides" and looked close because she could not see her chest move. The Service Recipient's breathing was staggered, and she was gasping for breath. The Subject stated that the way the Service Recipient was laying "was alarming" because the Service Recipient was flat on her back and always slept upright. The Subject paged the on-call nurse at 11:15 p.m. (Justice Center Exhibits 11, 13, 20 and 35; Subject Exhibit A)

The on-call nurse tried to call the house number, but it was busy. The Subject was speaking with the Service Recipient's brother who stated that he was concerned about the Service Recipient because he thought she was not acting normal when he saw her earlier that day. He requested that the Subject call the house manager and the nurse. The call began at 11:16 p.m. and lasted 24 minutes. The Subject paged the on-call nurse at 11:41 p.m. At 11:43 p.m., the on-call nurse telephoned the house and spoke with the Subject. The Subject informed the on-call nurse that the Service Recipient was nonresponsive, cold to the touch, short of breath, very pale and had been gasping for air all day and that they were unable to get a blood pressure or temperature reading on the Service Recipient. The on-call nurse instructed the Subject to telephone 911 and the Subject told the on-call nurse that she would do so right away. (Justice Center Exhibits 11, 13, 20 and 37; Subject Exhibits A, B and C)

The Subject telephoned the house manager who was also her supervisor. The Subject's

supervisor arrived at the IRA and after checking the Service Recipient, instructed the Subject to call the on-call nurse back. At 12:05 a.m., the Subject paged the on-call nurse. At 12:06 a.m., the on-call nurse called the house back and asked if the ambulance had arrived. The Subject informed the on-call nurse that she had not yet telephoned 911 because they were looking for staff coverage to come in. The on-call nurse instructed the Subject to telephone the ambulance right away because they did not need staff to go with the Service Recipient. The Subject told the on-call nurse that she would do so. (Justice Center Exhibits 11, 13 and 20; Subject Exhibits A, B and C)

The Subject telephoned 911 at 12:09:52 a.m. on [redacted]. The Subject stated: "I don't know why I didn't call 911 when the nurse said to call". (Justice Center Exhibits 9, 13 and 20)

The Subject received American Red Cross Adult First Aid/CPR/AED training two times; the first in August of 2014 and the second in June of 2016. This certification was valid for two years and hence in effect at the time of the alleged incident. This training included directives that trouble breathing is an emergency condition requiring 911; unresponsiveness and trouble breathing are all signs of a life-threatening emergency and that life-threatening emergencies require a call to 911. (Justice Center Exhibits 20 and 36)

The telephone triage protocol of the [redacted] states that staff will be instructed that at any time they believe there is a life-threatening emergency they are to call 911 immediately. "They do not have to wait for permission from a nurse to do so." (Justice Center Exhibit 7)

Accordingly, the Subject breached her duty to the Service Recipient by not calling 911 immediately upon observing the Service Recipient gasping for breath and by waiting 26 minutes after the nurse's directive prior to telephoning 911. (Justice Center Exhibits 7, 11, 13, 20 and 36; Subject Exhibits A and B)

The Subject's breach caused physical injury to the Service Recipient. Physical injury is defined as any confirmed harm, hurt or damage resulting in a significant worsening or diminution of an individual's physical condition. (SSL § 488(6)) When the EMT arrived at the IRA he stated, "We could tell that the Pt. [Service Recipient] was in serious condition and noted an "audible wheeze". The emergency room physician stated that the Service Recipient was hypoxic with a low oxygen saturation level in route to the hospital; that she had altered vital signs, altered labs and was ultimately diagnosed with septic shock with multi organ failures. Her examination upon arrival at the hospital revealed that the Service Recipient's hands and feet were mottled and cool to the touch and that she was hypothermic with a body temperature of 88.5. The Service Recipient's laboratory results indicated acute renal failure and shock liver, along with respiratory acidosis and dehydration. The sepsis caused an alteration in the Service Recipient's clotting pathways and the intracranial hemorrhage that developed and resulted in the Service Recipient's demise resulted from her inability to clot. The emergency room physician stated that the sooner the Service Recipient would have gotten to the emergency room, the better her ultimate chances were going to be. He additionally stated that any delay is a higher risk of death for sepsis. Clearly, the Subject's breach caused physical injury. (Justice Center Exhibits 14, 15, 31 and 37)

The evidence establishes that the Subject committed neglect when she failed to provide adequate and timely medical care to the Service Recipient. 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. A Category 1 substantiation, as alleged, requires a finding that the Subject's failure to perform a duty

was knowing, reckless or criminally negligent and resulted in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part; or is likely to result in either. (SSL § 493(4)(a)(ii))

The Justice Center argued that the Subject's failure to perform her duty was reckless. Social Services Law defines the term "recklessly" as having the same meaning as provided in New York Penal Law § 15.05. (SSL § 488(16)) New York Penal Law § 15.05(3) states that a person acts "recklessly with respect to a result or to a circumstance" when the person is "aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation."

The Subject knew from her American Red Cross Adult First Aid/CPR/AED training that trouble breathing is a life-threatening emergency condition requiring 911. When the Subject first encountered the Service Recipient, she stated that she had to get close to her chest to make sure she was breathing, that the Service Recipient's breathing was staggered and that she was gasping for air. The telephone triage protocol of the facility stated that if staff believe there is a life-threatening emergency, they are to call 911 immediately, and do not have to wait for permission from a nurse. Notwithstanding her training and the facility protocol, the Subject paged the on-call nurse at 11:15 p.m. and then stayed on the telephone for 24 minutes with the Service Recipient's brother while the Service Recipient was gasping for breath. During this time, the on-call nurse could not get through to the house, because the telephone was busy. The on-call nurse finally got through to the facility at 11:43 p.m. and instructed the Subject to call 911, which the Subject said

she would do right away. Despite the nurse's directive, the Subject did not call 911 until 12:09 a.m. and only after the on-call nurse had called back to ascertain whether the ambulance was on the way. The Subject was aware of the risk of not calling 911 because the Subject informed the on-call nurse a 11:43 p.m. that the Service Recipient was nonresponsive, cold to the touch, short of breath, very pale and had been gasping for air all day. The Subject consciously disregarded this risk and engaged in conduct that represented a gross deviation from the standard of conduct that a reasonable person would observe in the situation. People v. Atkinson, 21 A.D.3d 145, 146; 799 N.Y.S.2d 125, 129 (2d Dept. 2005) The Subject's failure to perform her duty and telephone 911 was reckless. (Justice Center Exhibits 7, 9, 11,13, 20 and 36; Subject Exhibits A, B and C)

It must next be determined whether the Subject's failure to perform her duty resulted in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part; or is likely to result in either. (SSL § 493(4)(a)(i)(ii)) When the EMT arrived at the IRA he stated, "We could tell that the Pt. [Service Recipient] was in serious condition and noted an "audible wheeze". The emergency room physician stated that the Service Recipient was hypoxic with a low oxygen saturation level in route to the hospital; that she had altered vital signs, altered labs and was ultimately diagnosed with septic shock with multi organ failures. The Service Recipient's laboratory results indicated acute renal failure and shock liver, along with respiratory acidosis. The sepsis caused an alteration in the Service Recipient's clotting pathways and the intracranial hemorrhage that developed and resulted in the Service Recipient's demise was caused by her inability to clot. The emergency room physician stated that the sooner the Service Recipient would have gotten to the emergency room, the better her ultimate chances were going to be. He additionally stated that any delay is a higher risk of death for sepsis. The Subject's failure to

perform her duty resulted in physical injury that created a substantial risk of death and impairment of the function of the Service Recipient's bodily organs, namely her liver and kidneys. (Justice Center Exhibits 14, 15, 31 and 37)

The Justice Center has sufficiently established that the Subject committed Category 1 conduct. 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 1 act.

A substantiated Category 1 finding of abuse and/or neglect will result in the Subject being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 1 report will be disclosed to entities authorized to make inquiry to the VPCR. Substantiation of a Category 1 offense permanently places the Subject on the Staff Exclusion List.

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 1 act.

This decision is recommended by Keely D. Parr, Administrative Hearings Unit.

DATED: November 2, 2020
Brooklyn, New York

Keely D. Parr, ALJ