

██████████

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED: The request of ██████████ that the report substantiated on ██████████
██████████ dated and received on ██████████
██████████ 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.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: October 13, 2015
Schenectady, New York



David Molik
Administrative Hearings Unit

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for abuse and/or 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 report "substantiated" on [REDACTED] [REDACTED], dated and received on [REDACTED] of neglect by the Subject of a Service Recipient.

2. After investigation the Justice Center concluded that:

Offense 1

It was alleged on [REDACTED], at the [REDACTED] [REDACTED], located at [REDACTED], while acting as a custodians¹ (Direct Care Counselor), you committed an act of neglect when you failed to follow patient fall procedure and assumed a service recipient could walk and bear weight, despite her complaints of pain to her right leg and hip².

This offense has been SUBSTANTIATED as a Category 3 offense pursuant to Social Services Law § 493. (Justice Center Exhibit 1)

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

4. The [REDACTED], is a private corporation that operates

¹ The plural "custodians" appears in the substantiation letter of [REDACTED]. (Justice Center Exhibit 1)

² At the hearing, the Justice Center put forth two distinct factual allegations to support this one theory of substantiation. The factual allegations were offered separately under the theory that individually either could support the substantiated conclusion in Offense 1.

██████████
an ██████████, located at ██████████
██████ (the Home), and is certified by the New York State Office for People With Developmental Disabilities (OPWDD). The Home is 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 the Home as a Community Living Skills Counselor and was working in that capacity at the Home. Also at the time of the alleged neglect, the Subject was assigned to medication administration and general care of the Service Recipient, who was the object of the Subject's alleged neglect, and other residents of the Home. (Justice Center Exhibit 14, hearing testimony of Facility Quality Management ██████████ and hearing testimony of the Subject)

6. At the time of the alleged neglect, the Service Recipient was a person who was sixty-three years of age with a diagnosis of schizophrenia, paranoid chronic and mild mental retardation. (Hearing testimony of Facility Quality Management ██████████)

7. On ██████████, the Service Recipient fell and sustained a hip injury and was prescribed the narcotic pain killer Tramadol. At the time of that fall, an X-Ray revealed no evidence of fracture and medical providers documented a contusion of the hip. (Justice Center Exhibit 22)

8. Nine days later, on ██████████, at approximately 7:30 p.m. the Service Recipient requested pain relief; the Subject then consulted with the Registered Nurse and was granted permission to administer Tramadol. The Subject then administered Tramadol to the Service Recipient. (Hearing testimony of Facility Quality Management ██████████ and Justice Center Exhibit 22)

9. At Approximately 7:45 p.m., the same evening another staff member and the

██████████

Subject were in the lower level of the Home when the other staff member heard a noise that sounded like something had fallen on the second floor. The other staff member first responded to investigate the noise. The Subject followed shortly thereafter. (Justice Center Exhibit 16 and hearing testimony of the Subject) The other staff member discovered that the Service Recipient had fallen and was lying on the floor in her bedroom. The other staff member asked the Service Recipient to remain still, then went to the top of the stairs and yelled to the Subject to come upstairs and assist her. (Justice Center Exhibits 12, 16 and 20 and hearing testimony of Facility Quality Management Specialist ██████████)

10. The Subject went upstairs and entered the Service Recipient's room. The Subject and the other staff asked the Service Recipient: "if she was o.k, and she said she was in some pain." The Subject attributed this pain to the fall. (Hearing testimony of Subject) The other staff member and the Subject assisted the Service Recipient off of the floor and onto her bed. (Hearing testimony of Facility Quality Management Specialist ██████████ and Justice Center 19)

11. The Subject then telephoned the Registered Nurse and was instructed by the Nurse to have the Service Recipient lay down, place a cold cloth with ice on her hip, look for any visible injuries or warning signs of injury and check her glucose level, all of which the Subject and the other staff member did. The Subject reported to the Registered Nurse that they found no signs of injury, other than the bruise on the Service Recipient's hip, that the Service Recipient had sustained during the fall one week before. At the onset of the phone call, the Registered Nurse assumed that the Service Recipient was in the same position that she had been in, when discovered by staff. However, the Subject did not actually tell the Registered Nurse that the Service Recipient had not been moved. The Registered Nurse instructed the Subject and staff to

██████████

check the Service Recipient's legs to make sure that they "looked normal"³ The Registered Nurse did not follow any particular protocol for instructing the Subject in assessing the Service Recipient.⁴ (Hearing testimony of Registered Nurse ██████████)

12. The examination proved negative and the Registered Nurse ██████████ advised the Subject and staff to assist the Service Recipient into bed. (Hearing testimony of Registered Nurse ██████████)

13. The Registered Nurse then instructed the Subject that the Service Recipient should get some rest and see if the pain medication (Tramadol), that she had taken at approximately 7:30 p.m., would alleviate her pain. (Justice Center Exhibits 8, 9, 12, 19 and 20, hearing testimony of Facility Quality Management Specialist ██████████, hearing testimony of the Subject)

14. A short while later the Subject and other staff member assisted the Service Recipient with walking to the bathroom. The Service Recipient limped most of the way. (Justice Center Exhibit 16) At some point after the bathroom trip, the Subject telephoned Registered Nurse ██████████ and reported that the Service Recipient had walked to the bathroom with assistance. (Justice Center Exhibit 16 and hearing testimony of Subject) The Registered Nurse ██████████ instructed the Subject to have the Service Recipient lay down to see if she could get some sleep and also to monitor the Service Recipient and assist the Service Recipient if she needed to get up. (Justice Center Exhibits 10, 12 and 16 and hearing testimony of the Subject)

³ The assessment of "normal" consisted of determining whether there were open fractures or posture abnormalities. Staff was not authorized or trained to touch the hip or hips during the examination. (Hearing testimony of Registered Nurse ██████████)

⁴ The nurse testified that from time to time she relied upon an unspecified nursing manual provided by the employer for telephonically assisting staff in assessing injuries, but did not do so during this incident.

██████████

15. At approximately 10:15 p.m. the Subject telephoned the Registered Nurse to report that the Service Recipient had not fallen asleep and was still in pain. The Registered Nurse determined that the Service Recipient should be taken to the hospital emergency room and asked the Subject if she thought the Service Recipient could get up and get dressed. The Registered Nurse then asked the Subject if she thought the Service Recipient could walk and go down the stairs. The Subject then asked the Service Recipient the same question. The Service Recipient told the Subject that she believed that she could. (Hearing testimony of Subject) The Subject told the Registered Nurse that she thought the Service Recipient could do that as well. (Justice Center Exhibits 11, 12, 15 and 16 and hearing testimony of Registered Nurse ██████████ ██████████)

16. After the telephone call with the Registered Nurse, the Subject, and the other staff member helped the Service Recipient walk from her bedroom down a full flight of stairs to the lower level of the home. During the stairway descent, which took about fifteen minutes, the Service Recipient was afraid of falling and experienced pain but no more pain than she had experienced the rest of the evening. Once on the first floor the Service Recipient was put in a chair and wheeled outside to be taken to the hospital. (Justice Center Exhibits 15, 16, 19 and 20, hearing testimony of Registered Nurse ██████████, hearing testimony of Facility Quality Management Specialist ██████████ and hearing testimony of the Subject)

17. As a result of the Service Recipient's fall on ██████████ the Service Recipient was admitted into ██████████ General Hospital and diagnosed with a right femoral neck (hip) fracture. (Justice Center Exhibit 21 pages 1 and 15)

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 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 abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h), to include:

"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 abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3 abuse or neglect, which means:

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 abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse and/or 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 abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report. If, as in this matter, a Category 3 finding of neglect is upheld, the Subject will not be placed on the Justice Center's Staff Exclusion list (SEL) and the record will be sealed after five years.

If the Justice Center did not prove the abuse and/or neglect by a preponderance of 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 a prohibited act described in the substantiated report. The evidence established that the Subject moved the Service Recipient after she fell, and did so before contacting the

Registered Nurse, all in contravention of her employer's policy. The Justice Center has not established by a preponderance of evidence that the Subject committed neglect by allowing the Service Recipient to move down the stairs after she sustained a broken hip. The failure of the Subject to contact the Registered Nurse before she moved the Service Recipient from the floor to her bed constitutes an act of neglect.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-22) The investigation underlying the substantiated report was conducted by Facility Quality Management Specialist [REDACTED] and Facility Quality Management Specialist [REDACTED], two internal investigators employed by the provider agency.

After completion of the investigation, Justice Center investigator [REDACTED] conducted a paper review of the investigation completed by Facility Quality Management Specialist [REDACTED] and Facility Quality Management Specialist [REDACTED].

At the hearing, Justice Center investigator [REDACTED], Facility Quality Management Specialist [REDACTED] and Facility Quality Management Specialist [REDACTED] testified on behalf of the Justice Center. The Subject testified on her own behalf, presented the testimony of Registered Nurse [REDACTED] and presented no exhibits.

Theory I: Moving Service Recipient before Contacting the Nurse

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect by moving the Service Recipient from where she had fallen to the floor, to her bed before contacting the Registered Nurse in direct contravention of the facility's fall protocol. (Justice Center Exhibit 18)

The facts are largely undisputed with the exception of the timing of the telephone call by

██████████

the Subject to the Registered Nurse. The Justice Center contends that the Subject and the other staff member helped the Service Recipient off the floor and into her bed before contacting the Registered Nurse. The Subject contends that she and the other staff moved the Service Recipient from the floor to the bed only after contacting the Registered Nurse and receiving permission from the Registered Nurse to move the Service Recipient.

The record contains conflicting evidence concerning the timing of the telephone call to the Registered Nurse. Facility Quality Management Specialist ██████████ investigated the incident and interviewed the Service Recipient and the other staff member who was present throughout the incident. Facility Quality Management Specialist ██████████ took no written or recorded statements from either witness. Instead, Facility Quality Management Specialist ██████████ created bullet point notes of her respective interviews. (Justice Center Exhibits 19 and 20)

During their respective interviews both the Service Recipient and the other staff member stated that the Subject and the other staff member called the Registered Nurse after assisting the Service Recipient off the floor and onto the bed. (Justice Center Exhibits 19 and 20, hearing testimony of Facility Quality Management Specialist ██████████) The order of events given in the statements was confirmed by Facility Quality Management Specialist ██████████ who was ardent in her testimony that her bullet point notes correctly chronologized the order of events, as portrayed to her, during the investigative interviews. (Hearing testimony of Facility Quality Management Specialist ██████████).

In the relevant log, under the section labeled: "REASON FOR CALLING THE NURSE," the Subject wrote: "She said she fell a couple times, was in a lot of pain, and needed help walking. Helped her to her bed and didn't see any new bruises or marks." (Justice Center Exhibit 9) The

██████████

relevant portion of the long entry makes no mention of the conversation with the Registered Nurse, and this omission strongly suggests that when the Subject moved the Service Recipient from the floor to the bed, she had not yet telephoned the Registered Nurse.

The Registered Nurse testified that she believed, at the time of the telephone call with the Subject, the Service Recipient had just fallen and was on the floor but that she was not told by the Subject whether or not the Service Recipient was still on the floor, and she did not seek clarification either. (Hearing testimony of Registered Nurse ██████████) However, the Registered Nurse's note does indicate that she believed that the Service Recipient had been moved prior to the phone call. The Nurse wrote: "... I asked them if any part of her legs looked different before getting her up ..." (Justice Center Exhibit 12)

In both her hearing testimony and her interview during the investigation stage the Subject was adamant that she and the other staff member waited until they had permission from the Registered Nurse to assist the Service Recipient off the floor, and into the bed. (Justice Center Exhibit 16 p. 2, hearing testimony of the Subject)

In weighing the evidence, and in particular written records and interview notes, against the conflicting hearing testimony concerning the timing of the telephone call to the Registered Nurse, the weight of the evidence supports the conclusion that the Subject and the other staff member moved the Service Recipient from the floor to the bed before seeking guidance from the Registered Nurse, in contravention of facility policy.

Having concluded that the Subject and the other staff member moved the Service Recipient before consulting with and obtaining permission from the Registered Nurse, it must now be determined whether or not the Subject's conduct constitutes "neglect" as the term is defined in law. Neglect is defined as: "... 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.” [See NYS SSL §488(1)(h)] The Justice Center has sufficiently established that the Subject was a Custodian of the Service Recipient as she was assigned to the direct care of the Service Recipient, and the Subject’s duty as Custodian of the Service Recipient is outlined in the Facility’s “fall” protocol which provides, in the pertinent part, that: “In the event that an individual ... is found on the floor, staff will not attempt to move the individual ...” The protocol further states that: “Staff will also ... [c]ontact the Program Nurse, or Nurse On-Call for further instructions if: the individual complains of severe pain or acts as if in severe pain ...” Finally, the protocol states: “If the individual is not in pain, is not bleeding, is oriented, and head/neck trauma is not suspected assist the individual back to bed or into a chair ...” (Justice Center Exhibit 18)

Unfortunately, there is an obvious gap in the facility protocol between the conditions of “severe pain” and “not in pain” and as a result of this incident the relevant protocol was amended to clarify when the Registered Nurse was to be contacted, following a fall by a Service Recipient. (Hearing testimony of Facility Quality Management Specialist ██████████, hearing testimony of Facility Quality Management Specialist ██████████ and hearing testimony of Registered Nurse ██████████)

The relevant protocol directs that the Service Recipient can be moved only if she is experiencing no pain. The record reflects that the Service Recipient was in pain, and there is no indication that the Service Recipient suffered from bleeding, disorientation, or neck/head trauma. (Justice Center Exhibit 18) Consequently, by moving the Service Recipient, who expressed that she was in pain, before contacting the Registered Nurse, the Subject failed to follow the Facility’s fall protocol and therefore breached her duty to the Service Recipient.

Finally, the evidence establishes that the Service Recipient suffered from a right femoral neck (hip) fracture as a result of the fall. After the fall the Service Recipient was in pain. The Subject moved the Service Recipient, in contravention of provider agency policy, and this action breached the Subject's duty to the Service Recipient and this breach was likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition the Service Recipient.

Theory II: The Subject allowed the Service Recipient to walk downstairs after the fall

The Justice Center did not prove by a preponderance of the evidence that the Subject committed neglect by allowing the Service Recipient to walk down the stairs from the second floor to the first floor of the residence.

The facts are generally in agreement that the Subject and other staff member assisted the Service Recipient walking down a full flight of stairs, that during the descent the Service Recipient experienced pain and was scared of falling, and that the descent took ten to fifteen minutes. The Justice Center contends that the Subject knew or should have known that allowing the Service Recipient to walk down the stairs would place the Service Recipient at risk of further physical injury. The Subject contends that she and the other staff member relied on and acted on the decision and authorization of the Registered Nurse to move the Service Recipient from the second floor to the first floor.

There is no evidence in the record of any protocol established and employed by the Facility concerning moving a Service Recipient downstairs when injured. Additionally, the Registered Nurse testified that there is no formal protocol for making a determination about sending a Service Recipient to the hospital, but instead the Registered Nurse is to rely on his or her own judgment which is to be made from information elicited from the staff on the scene.

██████████
(Hearing testimony of Registered Nurse ██████████ ██████████) However, Facility Quality Management ██████████ concluded from her investigation that Registered Nurse ██████████ ██████████ failed to adequately communicate with the Subject and the other staff member. (Hearing testimony Facility Quality Management ██████████) Additionally, it is clear from the evidence in the record that the Registered Nurse also failed to consider the masking of pain that was likely occurring because the Service Recipient received a controlled substance pain medication, fifteen minutes before she fell.

The record reflects that the Subject and the other staff member contacted the Registered Nurse, while the Service Recipient was still in her bed, to tell the Registered Nurse that the Service Recipient's pain had not subsided and that the Service Recipient expressed a desire to go to the hospital. As a result of the call, the Registered Nurse determined that the Service Recipient should go the hospital. The Registered Nurse was told by the Subject that the Service Recipient had ambulated to the bathroom with assistance. (Justice Center Exhibit 15) Based upon this characterization, the Registered Nurse concluded that the Service Recipient's lower body was capable of full weight bearing. The Registered Nurse also asked the Subject if she thought the Service Recipient could descend the stairs. (Hearing testimony of the Registered Nurse ██████████) The Subject then asked the Service Recipient who replied that she could descend the stairs. (Hearing testimony of Subject)

The Registered Nurse then authorized the Subject and other staff member to have the Service Recipient walk down the stairs. (Justice Center Exhibits 12, 15 and 16, hearing testimony of Registered Nurse ██████████ and hearing testimony of the Subject) The record reflects that the Subject followed the instructions of the Registered Nurse. Consequently, the Justice Center did not establish that the Subject breached her duty to the Service Recipient

██████████
with regard to this factual allegation. The Justice Center did not prove neglect under that theory.

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 alleged neglect concerning the allegation of moving the Service Recipient who experienced pain after she fell and before contacting the Registered Nurse. The Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the alleged neglect concerning the allegation of moving the Service Recipient down the stairs. The substantiated report will not be amended or sealed.

Moreover, based upon the totality of the circumstances, the evidence and testimony presented, it is determined that the category of the affirmed substantiated neglect that such act constitutes was properly substantiated as a Category 3 act. A substantiated Category 3 finding 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 NY SSL § 496 (2). This report will be sealed after five years.

DECISION:

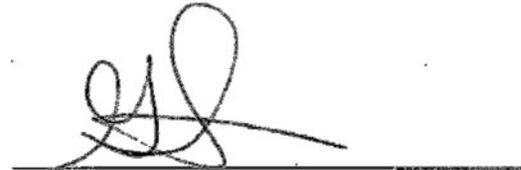
The request of ██████████ that the report substantiated on ██████████
██████████ dated and received on ██████████
██████████ be amended and sealed is denied. The Subject has been shown
by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 3.



This decision is recommended by Gerard Serlin, Administrative Hearings
Unit.

DATED: September 4, 2015
Schenectady, New York



Gerard Serlin, ALJ

A handwritten signature in black ink, consisting of a large, stylized 'G' and 'S' followed by a horizontal line extending to the right. Below the signature is a solid horizontal line.