

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

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In the Matter of the Appeal of

████████████████████

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AFTER HEARING**

**Adjud. Case #:**

████████████████

Vulnerable Persons' Central Register  
New York State Justice Center for the Protection  
of People with Special Needs  
161 Delaware Avenue  
Delmar, New York 12054-1310  
Appearance Waived

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

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By: Leonard Lato, Esq.  
200 Motor Parkway, Suite C-17  
Hauppauge, New York 11788

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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 substantiated report dated ██████████, ██████████, ██████████ 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.

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:** January 15, 2016  
Schenectady, New York

  
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David Molik  
Administrative Hearings Unit

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

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In the Matter of the Appeal of

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Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjudication Case #:**

████████████████

Before: Sharon Golish Blum  
Administrative Law Judge

Held at: New York State Justice Center for the Protection  
of People with Special Needs  
125 East Bethpage Road, Suite 104, Plainview,  
New York 11803

On: ████████████████████

Parties: Vulnerable Persons' Central Register  
New York State Justice Center for the Protection  
of People with Special Needs  
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Delmar, New York 12054-1310  
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**JURISDICTION**

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating ██████████ (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 substantiated report dated ██████████, ██████████ ██████████ 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 ██████████, while in Building █, at the ██████████ ██████████, located at ██████████, while acting as a custodian, you committed neglect when you failed to provide adequate medical care to a service recipient by failing to assess her condition when informed that she appeared to be unusually congested.

These allegations have been SUBSTANTIATED 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 ██████████, located at ██████████ ██████████, is a residential █ for adults with moderate to profound developmental disabilities and is operated by the New York State Office for People With

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Developmental Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the facility was composed of Building █ and Building █, each having separate service recipients and assigned staff. Fifteen service recipients resided in Building █. (Hearing testimony of DSA ██████████)

6. At the time of the alleged neglect, the Subject, ██████████, who had been employed as a Registered Nurse (RN) by OPWDD for seven years, was assigned to be the day nurse at Building █ of the facility. The Subject's regular hours of employment were ██████████. (Hearing testimony of the Subject)

7. At the time of the alleged neglect, the Service Recipient was a sixty year old resident of the facility's Building █. The Service Recipient is a person with a diagnosis of profound mental retardation and she suffered from sinusitis as well as numerous other physical and mental health issues. The Service Recipient is non-verbal and although she is ambulatory, she is blind and completely dependent, requiring assistance with all of her activities of daily living. (Justice Center Exhibits 11, 14 and 17)

8. At approximately 6:00 p.m. on ██████████, the Subject, who was not scheduled to be working, attended Building █ of the facility for the purpose of catching up on administrative duties that she had not performed during her regular work shifts. It was not unusual for the Subject to attend the facility when she was off duty to do her paperwork and charting. (Hearing testimony of the Subject)

9. Shortly after the Subject arrived at the facility, while she was reviewing the service recipients' medical charts in Building █ common room, she was approached by Direct Support Assistant (DSA) ██████████. DSA ██████████ complained to the Subject

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 about Licensed Practical Nurse (LPN) ██████████, who was on duty for Buildings █ and █ at the time. DSA ██████████ told the Subject that he had telephoned LPN ██████████ much earlier<sup>1</sup> to report his concern regarding the Service Recipient's condition and that LPN ██████████ had responded that he was busy with another service recipient in Building █, but that he would come to check on the Service Recipient in "a few minutes." DSA ██████████ expressed his frustration to the Subject that LPN ██████████ had not yet come to see the Service Recipient. (Hearing testimony of the Subject and DSA ██████████)

10. DSA ██████████ further communicated to the Subject his concern regarding the Service Recipient's condition. He expressed that the Service Recipient's nose was very runny and that she was having an unusual amount of mucus.<sup>2</sup> The Subject responded by reminding DSA ██████████ that the Service Recipient needs to be given her saline nose spray regularly. DSA ██████████, who was working nearby, overheard the conversation. DSA ██████████ then interjected that saline spray is just salt water, implying that it was her opinion that the Service Recipient required a more powerful remedy. (Hearing testimony of the Subject and DSA ██████████ and Justice Center Exhibits 5 and 6)

11. The Service Recipient's condition was not medically assessed on ██████████. The following day, on ██████████, the Service Recipient was taken to the

<sup>1</sup> Evidence that DSA ██████████ had telephoned LPN ██████████ at approximately 4:30 p.m. and that his conversation with the Subject regarding the matter occurred after 6:00 p.m. is consistent throughout the record.

<sup>2</sup>The substance of the communication by DSA ██████████ to the Subject is in dispute. DSA ██████████ wrote in his Statement dated ██████████ (Justice Center Exhibit 6) and testified at the hearing that he told the Subject that the Service Recipient was having an unusual amount of mucus and that the Service Recipient had "spit up" her medication due to the heavy mucus. The Subject told OPWDD Investigator ██████████ on ██████████, that, although DSA ██████████ had told her about the mucus, which was a regular issue for the Service Recipient, he had not mentioned that the Service Recipient had "spit up" her medication. (Justice Center Exhibit 16) The Subject testified at the hearing that DSA ██████████ had not used the word "mucus" when describing the Service Recipient's runny nose issue and, further, that he had not mentioned that the Service Recipient had "spit up" her medication.

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emergency department of ██████████ Hospital, whereupon she was evaluated and admitted as a patient. The Service Recipient was thereafter diagnosed with pneumonia. (Justice Center Exhibits 4 and 17)

### **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 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 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). Under SSL § 488(1)(h) neglect is defined as:

"Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider

agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

The term "custodian" is defined by SSL § 488(2) as follows:

"Custodian" means a director, operator, employee or volunteer of a facility or provider agency; or a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to a facility or provider agency pursuant to contract or other arrangement that permits such person to have regular and substantial contact with individuals who are cared for by the facility or provider agency.

Substantiated reports of abuse and/or 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(s) 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.

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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 the act described as Allegation 1 in the substantiated report. Specifically, the evidence establishes that the Subject committed an act of neglect under SSL § 488(1)(h) in that the Subject's inaction and lack of attention breached her duty to the Service Recipient which resulted in serious or protracted impairment of the physical condition of the Service Recipient.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-17) The investigation underlying the substantiated report was conducted by OPWDD Investigator ██████████, who, together with DSA ██████████, testified at the hearing on behalf of the Justice Center.

The Subject testified at the hearing on her own behalf and provided no other evidence.

The Justice Center's contention was that as a custodian, the Subject had a duty to assess the Service Recipient's condition once she became aware that the Service Recipient was secreting an unusual amount of mucus and that the Subject's neglect of that duty resulted in a delay in the Service Recipient's medical evaluation and treatment.

The Subject qualifies as a custodian even though she was not on duty at the facility. Under SSL § 488(2), the term "custodian" includes "an employee ... of a provider agency pursuant to contract or other arrangement that permits such person to have regular and substantial contact with individuals who are cared for by the facility or provider agency."

The Subject's defense to the allegation of neglect was that the Subject had not been made aware that there was any unusual concern about the Service Recipient's condition and,

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accordingly, her duty towards the Service Recipient had not been triggered. She testified at the hearing that DSA ██████████ did not tell her that the Service Recipient had “spit up” her medication, and that DSA ██████████ had not used the word “mucus” when he described the Service Recipient’s sinus condition to her. The Subject testified that it was common for the Service Recipient’s nose to be unusually runny. The Subject’s Counsel argued that because the Subject did not know that there was anything particularly unusual in the Service Recipient’s condition, the Subject had no duty to conduct a medical assessment of her.

Furthermore, the Subject’s Counsel submitted that the Subject’s response to DSA ██████████ ██████████ concerns had been an appropriate reaction to the information that she had received. Because the Subject had previously formulated a suspicion that the DSAs were not treating the Service Recipient with her saline nose spray as directed, she responded to DSA ██████████ ██████████ comments regarding the Service Recipient’s condition with a reprimand to use the saline nose spray regularly. In short, the Subject’s position was that she was unaware of the need to assess the Service Recipient and that her response to DSA ██████████ ██████████ communication to her had fulfilled her duty as a custodian.

Lastly, the Subject’s Counsel argued that DSA ██████████ ██████████ had embellished his account of his ██████████ ██████████ conversation with the Subject, by adding that he had told the Subject about the “spitting up” of the medication and that he had specifically used the term “mucus,” when he had done neither. The Subject’s Counsel suggested that this misrepresentation was offered by DSA ██████████ ██████████ in order to divert blame away from himself for failing to ensure that the Service Recipient was seen by a nurse. Counsel for the Subject pointed out that DSA ██████████ ██████████ signed a Statement dated ██████████ ██████████ (Justice Center Exhibit 6), and testified that he did not think that the Subject had understood

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what he had attempted to communicate to her during their conversation on ██████████. Counsel further pointed out that DSA ██████████ wrote in her Statement dated ██████████ (Justice Center Exhibit 5), that she did not think that the Subject had understood what DSA ██████████ had said to her. Counsel argued that the fact that the two DSAs had subsequently attempted to mitigate the harm they had done to the Subject, by providing her with the excuse that there had been a miscommunication, was evidence of their guilty consciences and proof that they had collaborated to concoct a fabricated version of the conversation which they had alleged had occurred between DSA ██████████ and the Subject on ██████████.

While it may be true that the two DSAs had attempted to soften the blow of their disclosures to OPWDD Investigator ██████████ by suggesting that the Subject had misunderstood DSA ██████████ concerns regarding the Service Recipient's condition, it does not follow that that suggestion is proof that DSA ██████████ had lied about or inflated the substance of what he had said to the Subject at the pertinent time.

In any case, regardless of whether DSA ██████████ had specifically mentioned the "spitting up" of medication or used the word "mucus," the fact remains that DSA ██████████ approached the Subject to communicate two key pieces of information about the Service Recipient to her. Firstly, DSA ██████████ expressed his frustration that he had contacted LPN ██████████ and requested that he come to check on the Service Recipient, and that LPN ██████████ had not come. Secondly, DSA ██████████ expressed his concerns regarding the Service Recipient directly to the Subject, and thereby reiterated that the Service Recipient's condition was unusual from his perspective. These two aspects of his communication to the Subject triggered her duty, as a custodian, to assess the Service Recipient herself. The Subject had been alerted to a problem and she failed to act on it as she should have

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in accordance with her duty.

As proof of the Subject's duty as an RN at the facility, the Justice Center provided two pages (Justice Center Exhibit 15), the first one being page thirty-three of fifty-one, entitled: Universal Protocol Surveyor Guidelines and the second one being page fourteen of twenty-seven, entitled: Universal Protocol Questions. While this evidence was not particularly helpful and its context was unclear, it did reinforce the obvious premise that, at the minimum, RNs have a duty to provide observation of the physical status of service recipients.

Accordingly, it is found that, under the circumstance, the Subject failed to provide adequate medical care to the Service Recipient by failing to assess her condition when informed that she appeared to be unusually congested.

Having concluded that the Subject breached her duty, it must also be determined whether the Subject's breach of duty resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. In general, the breach of a RN's duty to assess the condition of a service recipient when a caregiver has expressed concern, could obviously very likely result in a serious or protracted deterioration of the service recipient's physical condition. In this case, the Subject's breach of duty resulted in a delay in the evaluation of the Service Recipient's condition until the following day, when the Service Recipient was visibly unwell and taken to the hospital where she was admitted and subsequently diagnosed with pneumonia. Had the Subject assessed the Service Recipient a day earlier, at the time that DSA ██████████ had notified her of his concern regarding the Service Recipient's condition, the deterioration of the Service Recipient's physical condition that occurred during that interval would have been avoided. As a result, the Subject's breach of her duty did result in a serious and protracted impairment of the physical condition of the Service

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Recipient.

Accordingly, in the final analysis, based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed neglect as specified in Allegation 1 of the substantiated report.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse and/or 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.

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 substantiated report dated ██████████ ██████████, ██████████ 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 Sharon Golish Blum, Administrative Hearings Unit.

DATED: December 24, 2015  
Plainview, New York



Sharon Golish Blum, Esq.  
Administrative Law Judge