

**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

[REDACTED]  
[REDACTED]  
[REDACTED]

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AFTER HEARING**

**Adjud. Case #:**

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

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: Juliane O'Brien, Esq.

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By: Jonathan G. Johnsen. Esq.  
Creighton, Johnsen & Giroux  
560 Ellicott Square Building  
295 Main Street  
Buffalo, New York 14203





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 2 act.

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of these reports shall be retained by the Vulnerable Persons Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

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:** March 29, 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

[REDACTED]  
[REDACTED]  
[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjudication Case #s:**

[REDACTED] [REDACTED]  
[REDACTED] [REDACTED]  
[REDACTED] [REDACTED]  
[REDACTED] [REDACTED]

Before: Gerard D. Serlin  
Administrative Law Judge

Held at: New York State Justice Center  
Administrative Hearings Unit  
1200 East and West Road  
West Seneca, New York 14224-3604  
On: [REDACTED]

Parties: Vulnerable Persons' Central Register  
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  
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By: Juliane O'Brien, Esq.

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**Allegation 1**

It was alleged that on various dates between ██████████ and ██████████, at the ██████████, located at ██████████, while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

4. After investigation of ██████████ role in the report, the Justice Center concluded that:

**Allegation 1**

It was alleged that on various dates between ██████████ and ██████████, at the ██████████, located at ██████████, while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

**Allegation 2**

It was alleged that between ██████████ and ██████████, at the ██████████, located at ██████████, while acting as a custodian, you committed neglect when you failed to ensure that a service recipient received a treatment and dietary supplement in a timely fashion.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

5. After investigation of ██████████ role in the report, the Justice Center concluded that:

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**Allegation 1**

It was alleged that on various dates between ██████████ and ██████████, at the ██████████, located at ██████████, while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

6. After investigation of ██████████ role in the report, the Justice Center concluded that:

**Allegation 1**

It was alleged that on various dates between ██████████ and ██████████, at the ██████████, located at ██████████, while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

7. After investigation of ██████████ role in the report, the Justice Center concluded that:

**Allegation 1**

It was alleged that on various dates between ██████████ and ██████████, at the ██████████, located at ██████████, while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law §493(4)(b).

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8. After investigation of ██████████ role in the report, the Justice Center concluded that:

**Allegation 1**

It was alleged that on various dates between ██████████ and ██████████, at the ██████████, located at ██████████ ██████████, while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law §493(4)(b).

9. An Administrative Review was conducted and as a result, the substantiated reports were retained.

10. The facility, ██████████, is a group home located at ██████████, and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. Each of the Subjects was employed in the capacity of Direct Support Assistant (DSA). The Subjects were custodians as that term is so defined in Social Services Law § 488(2).

11. At the time of the alleged neglect, the Service Recipient had been a resident of the facility for approximately two years. The Service Recipient was a person who used a wheelchair, but could go from a seated to a standing position for transfers. The Service Recipient was also a person with an unspecified psychiatric disorder, diabetes and significant neuropathy. The Service Recipient also experienced fecal and urinary incontinence and utilized an adult diaper. (Hearing testimony of OPWDD RN ██████████, and Justice Center Exhibit 26) The Service Recipient had good verbal skills and was communicative. (Hearing testimony of OPWDD RN ██████████) Because the Service Recipient was diabetic and

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nearly always required a wheelchair, he historically suffered from pressure wounds on his buttocks. Sometime in ██████████, the Service Recipient recovered from pressure wounds that had healed after a course of treatment. (Hearing testimony of OPWDD RN ██████████ ██████████)

12. The Service Recipient attended a day program Monday through Friday and departed from his residence to his day program by 7:30 a.m. each morning. (Hearing testimony of OPWDD Investigator ██████████) On ██████████<sup>1</sup>, staff at the day program discovered and documented two pressure wounds on the Service Recipient's buttocks. (Hearing testimony of OPWDD RN ██████████)

13. On ██████████, a facility direct care staff member documented one wound on the left buttock as being 2 cm by 1 cm and one wound on the right buttock as being 1.5 cm by .5 cm, with no swelling noted. (Justice Center Exhibit 26)

14. The Service Recipient had a medical appointment on ██████████, in which a medical practitioner evaluated the pressure wounds and noted the wounds to be two "pea sized" wounds 1 cm by .5 cm on the buttocks, with no evidence of infection. The medical practitioner prescribed Allevyn adhesive dressing (the dressing), 3 inch by 3 inch size to be applied once daily. (Justice Center Exhibits 12 and 13) Subject ██████████ accompanied the Service Recipient to this medical appointment. (Hearing testimony of Subject ██████████) The purpose of the dressing was not only to protect the wound from debris and foreign organisms but also to promote healing by maintaining a specified temperature range and keeping the wound moist. Once the dressing was removed and reapplied, it could take as many as four hours for the

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<sup>1</sup> The record is not clear. The discovery of the pressure wound was made on either the ██████████ ██████████ (Justice Center Exhibit 40, p. 4 and Hearing testimony of OPWDD RN ██████████)











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29. On ██████████, Subject ██████████ signed the MAR indicating that she had changed the dressing that covered the Service Recipient's wounds, but in fact, she did not apply the dressing and she likely relied upon the representation of another employee that the dressing had been changed. (Justice Center Exhibit 36, p. 8, lines 19-23 and Hearing testimony of Subject ██████████)

Subject ██████████

30. Subject ██████████ worked the overnight shift (11:00 p.m. to 7:00 a.m.) on the following dates: ██████████. (Justice Center Exhibit 28 and Hearing testimony of Subject ██████████) On ██████████, she worked the 7:00 a.m. to 11:00 a.m. shift. (Justice Center Exhibit 37, p. 5, lines 19-22 and Hearing testimony of Subject ██████████)

31. Subject ██████████ placed her initials in the MAR indicating that she changed the dressing on ██████████, and ██████████.<sup>4</sup> (Hearing testimony of Subject ██████████ and Justice Center Exhibit 27) However, on each of those dates, rather than changing the Service Recipient's dressing herself, she instead relied upon her supervisor's representation that the dressing had already been changed. (Hearing testimony of Subject ██████████ and Justice Center Exhibit 27)

32. Subject ██████████ failed to document the condition of the wounds in the residential notes, as directed by the PONS, on any date when she changed the dressing, or on any date which she represented in the MAR that she had changed the dressing. (Justice Center Exhibit 26)

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<sup>4</sup> The record is unclear as to which shift this Subject worked on ██████████; however, at the hearing this Subject testified that, on this date, although she documented in the MAR that she had administered the dressing, she had not in fact done so.



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████ noted in the MAR that he had changed the dressing on both dates. (Justice Center Exhibit 27)

37. Subject ██████████ failed to document the condition of wounds in the residential notes, as directed by the PONS, on any date when he changed the dressing or on any date when he represented in the MAR that he had changed the dressing. (Justice Center Exhibit 26)

Subject ██████████

38. On unknown dates between ██████████ and ██████████, Subject ██████████ worked with multiple staff to change the Service Recipient's dressing. On one of those occasions, he changed the dressing but another staff member signed the MAR indicating that he, rather than Subject ██████████, had changed the dressing. (Hearing testimony of Subject ██████████)

39. Subject ██████████ failed to document the condition of wound in the residential notes at any time and on any date when he changed the dressing or on any date when he represented in the MAR that he had changed the dressing. (Justice Center Exhibit 26)

40. At some point in time between ██████████ and ██████████, Subject ██████████ observed the house supervisor having a discussion with Nurse-A. Shortly thereafter, the house supervisor advised him that Nurse-A directed that staff should remove the dressing to "air it out" at night. Because of the house supervisor's directive, on an unknown date, sometime between ██████████, and ██████████, Subject ██████████ removed the dressing from the Service Recipient's pressure wound and left the wound to air out overnight. (Hearing testimony of Subject ██████████)

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Subject ██████████

41. On ██████████, Subject ██████████ worked the 3:00 p.m. to 11:00 p.m. shift. (Hearing testimony of Subject ██████████) She was assigned the task of medication administration but because of the house supervisor's directive to allow the Service Recipient's wounds to air out, she failed to reapply the Service Recipient's dressing after she administered the gel at 8:00 p.m.

42. On ██████████, Subject ██████████, though obligated to do so, failed to properly verify the correct transcription of the medical practitioner's orders of ██████████, into the MAR.

Time period of ██████████ to ██████████

43. The supplement arrived at the facility on ██████████. (Justice Center Exhibit 41, p. 31)

44. On ██████████, OPWDD notified the Justice Center of these issues, (Justice Center Exhibit 10), and OPWDD RN ██████████ took over responsibility for the wound care of the Service Recipient.<sup>5</sup> As of ██████████, direct care staff at the facility was no longer involved in the wound care of the Service Recipient. (Hearing testimony of OPWDD RN ██████████)

45. The Service Recipient was next evaluated by an outside medical practitioner on ██████████, when he was seen by a wound care practitioner. OPWDD RN ██████████ accompanied the Service Recipient to the medical appointment. The medical practitioner continued the most recent antibiotic prescription as written by the medical

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<sup>5</sup> Although OPWDD RN ██████████ testified that she took over the wound care of the Service Recipient on ██████████, the MAR indicates that the staff administered the dressing and the gel to the Service Recipient on ██████████, but not on any date thereafter. Therefore, it appears that OPWDD RN ██████████ took over care of the Service Recipient's wound on ██████████.

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practitioner two days prior, and additionally prescribed a chemical debridement agent, a medication intended to dissolve necrotic tissue in the wound. The wound could not be staged when viewed by the wound care practitioner because damaged tissue prevented good visualization of the wound. (Hearing testimony of OPWDD RN ██████████)

46. From ██████████ until ██████████, the Service Recipient was not seen by a health care practitioner other than RN ██████████, but phone consultations transpired between RN ██████████ and the wound care practitioner on a regular basis. The Service Recipient continued to display signs of active infection. (Hearing testimony of OPWDD RN ██████████)

47. On ██████████, the Service Recipient experienced a decline in his level of consciousness and was admitted to the hospital where he was diagnosed as septic, meaning that a bacterial infection was running throughout his body and was not localized. The Service Recipient underwent surgical debridement of the left buttock wound and was treated with a course of intravenous antibiotics, which lasted approximately two weeks. He remained hospitalized during this time. (Hearing testimony of OPWDD RN ██████████)

48. The Service Recipient then returned to the facility on or about ██████████,<sup>6</sup> and was prescribed oral antibiotics. The left buttock wound bed still had some yellow tissue. After a brief period “off of the oral antibiotics,” the odor returned to the wound, and the Service Recipient developed an elevated temperature. (Hearing testimony of OPWDD RN ██████████)

49. On or about ██████████,<sup>7</sup> the Service Recipient was again admitted to the hospital and was again treated with intravenous antibiotics. An MRI of the Service Recipient

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<sup>6</sup> The date was not definitively established in the record.  
<sup>7</sup> The date was not definitively established in the record.

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revealed a bacterial infection of the bone underlying the debrided wound bed. While in the hospital, a peripherally inserted catheter (PIC) was inserted into the Service Recipient for post-hospital administration of intravenous antibiotics specifically used in the treatment of bacterial infection of the bone. On or about ██████████,<sup>8</sup> the Service Recipient was released to a rehabilitation program for administration of the antibiotics specifically for the treatment of the bacterial bone infection. (Hearing testimony of OPWDD RN ██████████)

50. While in rehabilitation, the Service Recipient was seen at least once weekly by RN ██████████. A facility staff member was also assigned to the Service Recipient while he was in the rehabilitation center. (Hearing testimony of OPWDD RN ██████████)

51. On ██████████, while at the rehabilitation center, the Service Recipient's condition worsened and, as a result, he was admitted to the hospital with septicemia. The Service Recipient died on ██████████. (Justice Center Exhibit 34) The Service Recipient's death was, in part, attributable to his pressure wounds and the resulting septicemia. (Hearing testimony of OPWDD RN ██████████ and Justice Center Exhibit 34) At the time of the Service Recipient's death, his left buttock wound was described as a "sacral decubitus ulcer" with "osteomyelitis," and was classified as Stage 4 on the Service Recipient's "ischial tuberosity." (Justice Center Exhibit 34)

52. The osteomyelitis, or bone infection, appeared to start in the area of left buttock wound that had been surgically debrided while the Service Recipient was hospitalized on ██████████ ██████████. (Hearing testimony of OPWDD RN ██████████) It is also possible that the infection leading to the septicemia began in the PIC line that was installed in order to administer IV antibiotics to the Service Recipient during his stay at the rehabilitation center. (Hearing testimony of OPWDD RN ██████████) Although the wound was documented in the record as

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<sup>8</sup> The date was not definitively established in the record.

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being located on the Service Recipient's "ischium tuberosity," this same wound had persisted on the left buttock since ██████████. (Hearing testimony of OPWDD RN ██████████)

**ISSUES**

- Whether the Subjects have 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). Neglect under SSL § 488(1) (h) 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

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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 2, which is defined as follows:

- (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one 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 Subjects committed the acts of neglect alleged in the substantiated report that is the subject of the proceeding and that such 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 acts 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 Subject ██████████

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committed the acts described in Allegation 1 of the substantiated report.

The Justice Center has established by a preponderance of the evidence that Subject ██████ committed the acts described in Allegation 1 of the substantiated report. However, the Justice Center has not established by a preponderance of the evidence that Subject ██████ committed the acts described in Allegation 2 of the substantiated report.

The Justice Center has established by a preponderance of the evidence that Subject ██████ committed the acts described in Allegation 1 of the substantiated report.

The Justice Center has established by a preponderance of the evidence that Subject ██████ committed the acts described in Allegation 1 of the substantiated report.

The Justice Center has established by a preponderance of the evidence that Subject ██████ committed the acts described in Allegation 1 of the substantiated report.

The Justice Center has established by a preponderance of the evidence that Subject ██████ committed the acts described in Allegation 1 of the substantiated report.

The Justice Center has established by a preponderance of the evidence that Subject ██████ committed the acts described in Allegation 1 of the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-68)

The investigation underlying the substantiated report was conducted by OPWDD Investigator ██████████, who testified at the hearing on behalf of the Justice Center. OPWDD RN ██████████ also testified at the hearing on behalf of the Justice Center.

Each of the Subjects testified in their own behalf and provided no other evidence.

The hearing in this matter was conducted as a consolidated hearing, with eight Subjects. The substantiation letter for each Subject was virtually identical and the language used in the

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substantiated allegations for each Subject was the same, with the exception of one Subject. The Subjects' contact with the Service Recipient and consequently their omissions, or commissions regarding the Service Recipient, spanned approximately from ██████████, until ██████████.

Admitted on stipulation into the hearing record was the Notice of Discipline for each of the Subjects, together with their respective labor arbitration award. (Justice Center Exhibits 43-55) The admission of these documents did not result in a finding of issue preclusions and/or collateral estoppel in this hearing, and such relief was not requested. The entirety of this decision is based upon the independent evidence presented at the hearing.

While the facts are complex, in simple terms all of the Subjects were alleged to have failed to properly administer either the dressing or the gel, as well as having failed to document the condition of the wound in the residential notes. The PONS required documentation of the condition of the wounds in the residential notes whenever the dressing was changed. Direct care staff who changed the dressing in the morning should have documented the wound condition in the residential notes. (Justice Center Exhibit 23 and Hearing testimony of OPWDD RN ██████████)

Some of the Subjects were alleged to have documented that they had performed a dressing change, when in fact they had not, and had instead relied upon the representation of other direct care staff that the dressing change had been completed.

Subject ██████████ and Subject ██████████ were alleged to have incorrectly transcribed into the MAR the time for administering the gel, which ultimately caused the other Subjects to incorrectly administer the gel and the dressing. Had the MAR been correctly transcribed and the dressing and the gel been administered correctly, then both treatments would have been applied simultaneously each morning at approximately 7:30 a.m.

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The Subjects' counsel argued that there was no proof in the record that the Subjects failed to properly administer the Service Recipient's medication, and/or failed to accurately document administration of his medication, at least with regard to issues surrounding administration of the dressing. The basis for the Subjects' counsel's argument was that the dressing was not a medication.

The dressing was an adhesive bandage, specifically designed to promote wound healing, which was affixed to the wound area and was obtained for the Service Recipient by prescription from a medical professional. (Hearing testimony of OPWDD RN ██████████) Therefore, the Administrative Law Judge presiding over the hearing concludes that any reference to medication in the substantiation letters applies to both the gel and the dressing.

The ██████ Medication Procedure Manual (Justice Center Exhibit 21) outlines the process that the Subjects are required to follow in the administration of medicine, and specifically in the administration of the dressing and gel. With regard to the process dictated by the ██████ Medication Procedure Manual, the proof established that every medication label should be checked against the Service Recipient's MAR before administration to the Service Recipient, and this was the expectation under which the direct care staff worked. (Hearing testimony of OPWDD RN ██████████ and Justice Center Exhibit 21, p. 3)

In this case, the medication labels created by the pharmacy for the dressing and the gel were not preserved. (OPWDD Investigator ██████████) The prescription for the gel was transmitted electronically from the medical provider to the pharmacy, and a copy was not kept at the facility. (OPWDD Investigator ██████████) However, an electronic printout reciting the prescription, as provided by the medical provider, was generated by the pharmacy and was provided to the facility by the pharmacy. (Justice Center Exhibit 15, second page and Hearing

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testimony of OPWDD RN ██████████) The electronic prescription was reviewed by Nurse-A. (Justice Center Exhibit 15, second page) However, the only administration directions regarding the gel that were contained in the electronically generated prescription were as follows: “apply to open area of left buttock wound QD one wound.” (Justice Center Exhibit 15, second page) There was no directive to apply the gel along with the dressing, and the time for administration was not prescribed.

The medical practitioner’s Clinical Visit Summary of ██████████, also did not specify a time of day for administration of either the gel or the dressing, and contained essentially the same directions as the prescription: “... apply to open area of left buttock wound QDone wound”, with no directive that the gel was to be administered along with the dressing. (Justice Center Exhibit 14) Additionally, the PONS created on ██████████, was not updated by Nurse-A to include the gel (although it should have been), until several days after the gel prescription was added. Had the PONS been updated properly, it would have included the directive to administer the dressing and the gel together. (Hearing testimony of OPWDD RN ██████████  
██████████)

The Subjects’ counsel also argued that, because the Subjects reasonably relied upon and followed the incorrect directives contained in the MAR, they did not breach their duty to the Service Recipient. The Administrative Law Judge presiding over the hearing concludes that the Subjects who followed the directives for administration of medication, meaning the dressing and gel as set forth in the MAR, did not breach their duty to the Service Recipient with regard to the timing of administration or method of administration of the gel and dressing. The nearly uncontroverted evidence in the record was that direct care staff who relied upon the MAR and



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to once. This resulted in an additional four-hour period each day when the wounds were not at optimal temperature and moisture level for healing.

There is a preponderance of the evidence in the record to conclude that leaving the wound uncovered during the overnight was a factor in the deterioration of the left buttock wound. Further, there is also a preponderance of the evidence in the record to conclude that because of the undiscovered error in the Service Recipient's MAR, the Service Recipient's left buttock wound went without gel for as many as twelve hours per day. The ██████████ medical directive (to administer the gel and the dressing together on the left buttock wound) was not followed for at least nine days. The evidence established that during that nine-day period, the Service Recipient's left buttock wound deteriorated, and by ██████████, the left buttock wound was filled with necrotic tissue and could not be staged because visualization of the wound bed was not possible.

The left buttock wound continued to deteriorate and the Service Recipient experienced sepsis for the first time in ██████████. On ██████████, the necrotic tissue in the wound on the left buttock was surgically debrided. An infection of the bone ensued in ██████████, which was believed to have started at the site of the surgical debridement. Ultimately, even after a six-week course of IV antibiotics, the Service Recipient experienced septic shock again and died in ██████████. The Service Recipient's pressure wounds were determined to be a contributing factor in his death.

There is a preponderance of the evidence in the record to conclude that had the wounds been cared for (in particular the left buttock wound) in conformity with the medical practitioner's instructions, that the PIC line which delivered intravenous antibiotics would not have been necessary. Therefore, even if the point of entry for the bacterial infection that led to septicemia,

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was the PIC line, the failure to provide proper wound care was a contributing factor in the septicemia and ultimately the death of the Service Recipient.

Subject ██████████ (Adjudication Case #: ██████████)

On ██████████, Subject ██████ signed the MAR indicating that she had changed the dressing to the Service Recipient's wounds but, in fact, she did not change the dressing herself.

On ██████████, Subject ██████ changed the dressing on the Service Recipient's wounds but Subject ██████ failed to document the condition of the wounds in the residential notes, as was directed by the PONS. Additionally, Subject ██████ failed to document the condition of the wounds on this date and all other dates on which she changed the dressing, or represented in the Service Recipient's MAR that she had changed the dressing.

The Justice Center has established by a preponderance of the evidence that Subject ██████ did not properly document the status updates for the Service Recipient's pressure wounds, and failed to accurately document administration of his medication.

The Justice Center proved by a preponderance of the evidence not only that Subject Slater's inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that Subject Slater committed the neglect alleged. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented, the witnesses'





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Subject ██████ hearing testimony was not only waffling and inconclusive on this issue, but was also contradicted in part by statements that she had made during interrogation by the OPWDD investigator. (See Justice Center Exhibit 40, pp. 8-10) The hearing testimony of the Subject on this issue is not credited evidence.

The Justice Center has established by a preponderance of the evidence that Subject ██████ failed to properly document the status updates for the Service Recipient's pressure wounds by failing to document the condition of the wounds in the residential notes after each dressing change, and also that she failed to accurately document administration of the Service Recipient's medication by documenting in the Service Recipient's MAR that she herself had changed the dressing, when she had not actually changed the dressing.

Concerning Allegation 1 pertaining to the Subject ██████, the Justice Center has established by a preponderance of the evidence that the Subject ██████ did not properly document the status updates for the Service Recipient's pressure wounds and did not accurately document administration of his medication.

However, with regard to Allegation 2 pertaining to the Subject ██████, the convincing evidence established that although the Subject ██████ was designated as the Medical Liaison for the residence, she did not become aware of the dietician's recommendation for administration of the supplement until after a medical practitioner prescribed the supplement, and that the house manager had the duty to obtain the supplement, not the Subject. Consequently, the Justice Center did not establish that Subject ██████ committed neglect by failing to ensure that the Service Recipient received a treatment and dietary supplement in a timely fashion.

With regard to Allegation 1, the Justice Center proved by a preponderance of the evidence not only that Subject ██████ inaction and/or lack of attention breached her duty to

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the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that Subject ██████ committed the neglect alleged. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of this Subject, Subject ██████ neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in this Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

Subject ██████ (Adjudication Case #: ██████)

On ██████, Subject ██████ worked the 3:00 p.m. to 11:00 p.m. shift. During her shift, the house supervisor instructed her to remove the dressing and leave the wounds uncovered during the overnight. At about 7:30 p.m. the Subject removed the dressing for the evening and documented the condition of the wound in the residential notes. (Justice Center Exhibit 38, p. 11; Justice Center Exhibit 26 and Hearing testimony of Subject ██████)

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The Justice Center also alleged that Subject ██████████ incorrectly transcribed the prescription for the dressing into the MAR on ██████████. OPWDD Investigator ██████████, who testified at the hearing on behalf of the Justice Center, concluded that the transcriber was not Subject ██████████, and that the transcriber was another facility direct care staff member. OPWDD Investigator ██████████ had noted this conclusion in her investigative report. (Justice Center Exhibit 11, p. 36 and Hearing testimony of OPWDD Investigator ██████████: day one, 4 hours and 33 minute mark)

Subject ██████████ testified credibly that she was not the direct care staff member who transcribed the information on that date. Subject ██████████ also corroborated Subject ██████████ testimony.

OPWDD RN ██████████ did testify at the hearing that she believed that the Subject ██████████ erroneously transcribed the prescription. However, it is determined that OPWDD RN ██████████ conclusion was in error and may have arisen from the fact that the direct care staff member who did transcribe the prescription has the same initials as Subject ██████████, ██████████

The Justice Center has established by a preponderance of the evidence that Subject ██████████ failed to properly administer the Service Recipient's medication in that she removed the dressing from the Service Recipient's wounds in contravention of medical orders, and left the wounds uncovered.

The Justice Center proved by a preponderance of the evidence not only that Subject ██████████ inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

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

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of this Subject, Subject ██████████ neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in this Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

Subject ██████████ (Adjudication Case #: ██████████)

Subject ██████ worked the 7:00 a.m. to 3:00 p.m. shift on ██████████ and ██████████. On both dates, Subject ██████ noted in the Service Recipient's MAR that he had changed the dressing. However, he did not change the Service Recipient's dressing. Subject ██████ also failed to document the condition of the wounds in the residential notes, as directed by the PONS, on any date on which he changed the dressing or on any date on which he represented in the Service Recipient's MAR that he had changed the dressing.

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The Justice Center has established by a preponderance of the evidence that Subject Paz failed to properly document the status updates for the Service Recipient's pressure wounds when he failed to document the condition of the wounds in the residential notes after each dressing change, and also that he failed to accurately document administration of the Service Recipient's medication when he documented in the Service Recipient's MAR that he himself had changed the dressing, when he had not actually changed the dressing.

The Justice Center proved by a preponderance of the evidence not only that Subject ██████ inaction and/or lack of attention breached his duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that Subject ██████ committed the neglect alleged. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of this Subject, Subject ██████ neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated report is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in this Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not

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elevated to a Category 1 finding shall be sealed after five years.

Subject ██████████ (Adjudication Case #: 521026758)

At some point in time between ██████████, and ██████████, Subject ██████ worked with multiple facility direct care staff members to change the Service Recipient's dressing. On one of those occasions, Subject ██████ changed the dressing but another staff member signed the Service Recipient's MAR indicating that the other staff member, rather than Subject ██████, had changed the dressing.

At some point in time between ██████████, and ██████████, Subject ██████ was instructed by the house supervisor to remove the dressing from the Service Recipient's pressure wounds. Subject ██████ did so and left the wounds uncovered for the overnight, to air out.

The Justice Center has established by a preponderance of the evidence that Subject ██████ failed to properly administer the Service Recipient's medication in that he removed the dressing from the Service Recipient's wounds, in contravention of medical orders, and left the wounds uncovered, and also that he failed to accurately document administration of the Service Recipient's medication when he allowed another facility direct care staff to document in the Service Recipient's MAR, that the direct care staff member had changed the dressing, when Subject ██████ had actually changed the dressing.

The Justice Center proved by a preponderance of the evidence not only that Subject Italia's inaction and/or lack of attention breached his duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, it is determined that the Justice Center has met its burden of proving by a



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obviously the person who transcribed it was instructed for 8 p.m.” There was no other evidence in the record that anyone instructed Subject ██████, or the other direct care staff member involved in the transcription on ██████████, to deviate from the Times Agreement. Subject ██████ did not make this assertion during the course of the investigation and made this allegation for the first time during her hearing testimony. Subject ██████ hearing testimony is not credited evidence on this issue.

Ultimately, all direct care staff relied upon this mistaken entry, and erroneously administered the gel at 8:00 p.m. instead of properly administering the gel along with the fresh dressing change at 7:30 a.m. each day.

On ██████████, at approximately 8:00 p.m., Subject ██████ was instructed by the house supervisor to leave the wounds without a dressing and uncovered. Subject ██████ applied the gel and did not reapply the dressing, leaving the wounds without a dressing during the overnight.

The Justice Center has established by a preponderance of the evidence that Subject ██████ failed to properly administer the Service Recipient’s medication in that she removed the dressing from the Service Recipient’s wounds in contravention of medical orders and left the wounds uncovered, and also failed to accurately document administration of his medication, when she did not discover a transcription error in the Service Recipient’s MAR made on ██████████ ██████████.

There is a preponderance of the evidence in the record to conclude that Subject ██████ neglect was the cause of the direct care staff’s failure to apply the gel and the dressing simultaneously, ultimately leaving the buttock wound without the gel for as many as twelve hours a day for nine consecutive days. This failure contributed to the worsening of the Service



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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 2 act.

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 2 act.

The request of ██████████ that the substantiated report dated ██████████, ██████████, ██████████ be amended and sealed is denied as to “Allegation 1”, but is granted as to “Allegation 2.” The Subject has been shown by a preponderance of the evidence to have committed neglect alleged in “Allegation 1” of the substantiation letter.

The substantiated report is properly categorized as a Category 2 act.

The request of ██████████ that the substantiated report dated ██████████, ██████████, ██████████ be amended and sealed is

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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 2 act.

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 2 act.

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 2 act.

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.

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The substantiated report is properly categorized as a Category 2 act.

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

**DATED:** February 26, 2016  
Syracuse, New York



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Gerard D. Serlin, ALJ