

**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]

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AND ORDER  
AFTER HEARING**

**Adjud. Case #:**

[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  
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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 granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

The request of ██████████ that the substantiated report dated ██████████ be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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The request of ██████████ that the substantiated report dated ██████████  
████████████████████ be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons Central Register, pursuant to SSL § 493(3)(d).

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:** May 4, 2016  
Schenectady, New York

  
\_\_\_\_\_  
David Molik  
Administrative Hearings Unit



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2.

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### JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subjects) for neglect. The Subjects requested that the VPCR amend the report to reflect that the Subjects are not the subjects of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

### FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [REDACTED] of neglect by the Subjects of a Service Recipient.

2. The Justice Center substantiated the report against the Subjects. The Justice Center concluded that:

#### **Allegation 1<sup>1</sup>**

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian, you committed neglect when you failed to seek medical attention to evaluate and/or treat a service recipient's knee, about which she complained and which was later determined to be dislocated.

This allegation has been SUBSTANTIATED as Category 3 neglect, pursuant to Social Services Law § 493.

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

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<sup>1</sup> The allegation is identical for each Subject.

4. The facility, located at [REDACTED], is a residential group home for adults with developmental disabilities, and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Service Recipient was fifty-seven years old, and had been a resident of the facility since [REDACTED]. The Service Recipient was diagnosed within the profound range of mental retardation. (Justice Center Exhibits 9 and 36)

6. The Service Recipient, who is non-ambulatory, can propel herself short distances in a wheelchair using her hands and feet, primarily her left foot. As a result, the Service Recipient's left leg, including her left knee, is physically larger than her right leg. (Justice Center Exhibit 36 and Hearing testimonies of OPWDD Investigator [REDACTED]<sup>2</sup>, Subject [REDACTED], Subject [REDACTED], Subject [REDACTED], Subject [REDACTED] and Subject [REDACTED])

7. The Service Recipient is mostly non-verbal but can indicate some of her needs and communicate responses to questions from facility staff, through grunts and gestures. The Service Recipient appears to understand simple questions and statements made by others. The Service Recipient indicates pain by crying, whining or pointing to the location on her body where she is experiencing pain. The Service Recipient often points to her head as an indication that she has a headache. (Justice Center Exhibit 36 and Hearing testimonies of OPWDD Investigator [REDACTED], Subject [REDACTED], Subject [REDACTED], Subject [REDACTED], Subject [REDACTED], Subject [REDACTED] and Subject [REDACTED])

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<sup>2</sup> [REDACTED] is presently employed by the New York State Justice Center for the Protection of People with Special Needs as an Investigator.

5.

8. Prior to [REDACTED], the Service Recipient required physical assistance transferring to and from her wheelchair. On [REDACTED], the Service Recipient suffered a dislocated left knee and, as a result of her injury, the use of a Hoyer Lift was required for such transfers. (Justice Center Exhibit 36 and Hearing testimonies of OPWDD Investigator [REDACTED], Subject [REDACTED], Subject [REDACTED], Subject [REDACTED], Subject [REDACTED] and Subject [REDACTED])

9. The Service Recipient was treated at [REDACTED] Medical Center on [REDACTED] [REDACTED] for a left patella-femoral dislocation. The hospital discharge instructions included directives to administer over-the-counter or prescription medications for pain, discomfort, or fever, and to apply ice to the Service Recipient's knee for fifteen to twenty minutes, four times per day. Further instructions to [REDACTED] staff included the use of a knee immobilizer on the Service Recipient's injured knee at all times and avoiding pivoting movements. (Justice Center Exhibit 38)

10. As a result of the Service Recipient's [REDACTED] knee injury, a Plan of Nursing Services (PONS) was created by the Staff RN for use by [REDACTED] direct care staff. The PONS directs, in relevant part, that [REDACTED] direct care staff will "Administer medications as prescribed for pain" and "Observe for and administer PRN<sup>3</sup> medications for pain/discomfort as ordered." The PONS further provides that [REDACTED] "Staff will contact RN if: -Pain is not relieved in one hour after PRN pain medication is given." The PONS was maintained and posted at the [REDACTED] and all of the Subjects were trained on and aware of its provisions. (Justice Center Exhibit 46)

11. Subjects [REDACTED] were Approved Medication Administration Personnel (AMAP) certified at the time of the alleged neglect. (Hearing testimony of Subjects [REDACTED]) The use of ice applied to the Service

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<sup>3</sup> PRN indicates that the medication is to be administered as needed.

Recipient's knee as basic first aid (the least invasive treatment), was taught as part of the AMAP certification. (Hearing testimony of [REDACTED])

12. At the time of the alleged neglect, Subject [REDACTED] was employed by OPWDD as a Developmental Assistant 2 (DA2) Supervisor and had been so employed since approximately 2004. On [REDACTED], Subject [REDACTED] worked at the [REDACTED] from 7:00 a.m. to 3:00 p.m. Subject [REDACTED] did not work at the [REDACTED] on [REDACTED]. (Justice Center Exhibit 47: Justice Center interrogation of Subject [REDACTED] and Hearing testimony of Subject [REDACTED])

13. At the time of the alleged neglect, Subject [REDACTED] was employed by OPWDD as a Direct Support Assistant (DSA) and had been so employed since 1984. On [REDACTED], Subject [REDACTED] worked at the [REDACTED] from 8:00 a.m. to 2:00 p.m. Subject [REDACTED] did not work at the [REDACTED] on [REDACTED]. (Justice Center Exhibit 47: Justice Center interrogation of Subject [REDACTED] and Hearing testimony of Subject [REDACTED])

14. At the time of the alleged neglect, Subject [REDACTED] was employed by OPWDD as a DSA and had been so employed since [REDACTED] 2007. On [REDACTED], Subject [REDACTED] worked at the [REDACTED] from 2:30 p.m. to 10:30 p.m. Subject [REDACTED] did not work at the [REDACTED] on [REDACTED]. (Justice Center Exhibit 47: Justice Center interrogation of Subject [REDACTED] and Hearing testimony of Subject [REDACTED])

15. At the time of the alleged neglect, Subject [REDACTED] was employed by OPWDD as a DSA and had been so employed since [REDACTED] 1988. On [REDACTED], Subject [REDACTED] worked from 1:00 p.m. to 9:00 p.m. Subject [REDACTED] did not

work at the [REDACTED] on [REDACTED]. (Justice Center Exhibit 47: Justice Center interrogation of Subject [REDACTED] and Hearing testimony of Subject [REDACTED]<sup>4</sup>)

16. At the time of the alleged neglect, Subject [REDACTED] was employed by OPWDD as a DSA and had been so employed since [REDACTED] 2008. On [REDACTED], Subject [REDACTED] worked a double shift at the [REDACTED] from 2:30 p.m. to 10:30 p.m. and then from [REDACTED] at 10:30 p.m. to [REDACTED] at 8:30 a.m. (Justice Center Exhibit 47: Justice Center interrogation of Subject [REDACTED] and Hearing testimony of Subject [REDACTED])

17. At the time of the alleged neglect, DSA [REDACTED] worked an 8:30 a.m. to 2:30 p.m. shift at the [REDACTED] on both [REDACTED] and [REDACTED], and Developmental Assistant 1 (DA1) [REDACTED] worked a 7:00am to 3:00pm shift at the [REDACTED] on [REDACTED]. (Justice Center Exhibit 47: Justice Center interrogation of DSA [REDACTED] and Hearing testimony of DA1 [REDACTED])

18. On [REDACTED] at 7:00 a.m., Subject [REDACTED] arrived at the [REDACTED] and started her shift. Subject [REDACTED] found the Service Recipient to be in good spirits. At 8:00 a.m., Subject [REDACTED] arrived at the [REDACTED] and started her shift. At 8:30 a.m., DSA [REDACTED] arrived at the [REDACTED] and started his shift. (Justice Center Exhibit 47: Justice Center interrogation of DSA [REDACTED] and Hearing testimonies of Subjects [REDACTED])

19. Shortly thereafter, Subjects [REDACTED] helped the Service Recipient transfer from her bed to her wheelchair using a Hoyer Lift. Subjects [REDACTED]

<sup>4</sup> Three different timeframes were provided by Subject [REDACTED] for the shift she worked on [REDACTED]. (Justice Center Exhibits 19 and 47, and Hearing testimony of Subject [REDACTED]) The timeframe credited in the facts was based on the hearing testimony of Subject [REDACTED]. The actual timeframe Subject [REDACTED] worked is not material to outcome of this determination.

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and ██████████ then took the Service Recipient to the bathroom to toilet and shower her. After toileting, DSA ██████████ showered the Service Recipient. Sometime after 8:30 a.m., Subject ██████████ administered routine morning medications to the Service Recipient. Tylenol was included as part of the Service Recipient's normal morning medication routine. (Justice Center Exhibit 47: Justice Center interrogation of DSA ██████████ and Hearing testimonies of Subjects ██████████)

20. At approximately 10:00 a.m., and before brunch, the Service Recipient pointed to her left knee. Subject ██████████ asked the Service Recipient if her knee hurt. The Service Recipient indicated through gestures and grunts that her knee did hurt. Subject ██████████, Subject ██████████ and DSA ██████████ looked at the Service Recipient's left knee and observed that her knee appeared the same as it had appeared since the Service Recipient's ██████████ injury. Because the Service Recipient indicated that her knee hurt, Subject ██████████ put an icepack on her knee. Subject ██████████ did not administer PRN Tylenol because an insufficient amount of time had passed, since Tylenol was administered to the Service Recipient in her morning medication regiment, for a second dose to be given<sup>5</sup>. After approximately ten minutes, Subject ██████████ asked the Service Recipient if her knee felt better. The Service Recipient responded by indicating through grunts and gestures that her knee did feel better. (Justice Center Exhibit 47: Justice Center interrogation of DSA ██████████ and Hearing testimonies of Subjects ██████████)

21. At approximately 11:00 a.m., after the Service Recipient ate brunch, she started whining. Subject ██████████, Subject ██████████ and DSA ██████████ examined the Service Recipient's left leg and found that her knee looked like it normally did after the

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<sup>5</sup> The Tylenol given to the Service Recipient in her regular morning and evening medication regiments was the same medication as the PRN Tylenol. (Hearing testimony of ██████████)

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██████████ injury. When asked by staff if her knee hurt, the Service Recipient indicated that it did. When asked by staff if her head hurt, the Service Recipient indicated that it did. Because the Service Recipient was indicating knee pain and/or a headache, Subject ██████████ administered PRN Tylenol to the Service Recipient. (Justice Center Exhibit 47: Justice Center interrogation of DSA ██████████ and Hearing testimonies of Subjects ██████████)

22. Thereafter, Subject ██████████, Subject ██████████ and DSA ██████████ transferred the Service Recipient to her recliner in the living room. Subject ██████████, Subject ██████████ and DSA ██████████ looked at the Service Recipient's left knee and observed it to appear no different than it normally did after the ██████████ injury. Approximately fifteen minutes after the administration of the PRN Tylenol, the Service Recipient was laughing and playful. Subject ██████████ asked the Service Recipient if her knee felt better and the Service Recipient indicated that it did. (Justice Center Exhibit 47: Justice Center interrogation of DSA ██████████ and Hearing testimonies of Subjects ██████████)

23. Thereafter, the Service Recipient sat in her recliner in the living room watching TV or sleeping until approximately 3:00 p.m. During that time Subjects ██████████ toileted the Service Recipient two or three times. Each time the Service Recipient was toileted, Subjects ██████████ used the Hoyer Lift to transfer the Service Recipient from her recliner to her wheelchair, the Standard to transfer the Service Recipient from the wheelchair to the toilet and back to the wheelchair after toileting, and the Hoyer Lift to transfer the Service Recipient from the wheelchair back to the recliner. Each





28. At 9:00 p.m., Subject [REDACTED] finished her shift and left the [REDACTED]. At 10:30 p.m. Subject [REDACTED] finished her shift and left the [REDACTED]. (Hearing testimonies of Subjects [REDACTED])

29. From the time that the Service Recipient went to bed and throughout the overnight, Subject [REDACTED] checked on the Service Recipient once every hour. During the overnight, Subject [REDACTED] changed the Service Recipient's diaper and repositioned the Service Recipient every two hours. The Service Recipient awoke each time that Subject [REDACTED] changed her diaper. However, the Service Recipient did not complain or otherwise indicate that she was experiencing any pain or discomfort, and she slept well throughout the night. (Hearing testimony of Subject [REDACTED])

30. On [REDACTED] at 6:00 a.m., DSA [REDACTED] arrived at the [REDACTED] and started his shift. Also at 6:00 a.m., Subject [REDACTED] administered the routine morning medications to the Service Recipient, including Tylenol. At some point between 6:30 a.m. and 7:00 a.m., Subject [REDACTED] discussed the Service Recipient's overnight condition with the Staff LPN. (Hearing testimony of Subject [REDACTED])

31. At 7:00 a.m., DA1 [REDACTED] arrived for her shift and was told by Subject [REDACTED] that the Service Recipient was whiny and complaining about her head and knee before going to bed. Subject [REDACTED] also told DA1 [REDACTED] that she and the other staff applied the icepack to the Service Recipient's left knee after putting her in bed. Subject [REDACTED] checked on the Service Recipient and found her asleep before leaving the [REDACTED] at 8:30 a.m. at the end of her shift. (Justice Center Exhibit 11 and Hearing testimonies of DA1 [REDACTED] and Subject [REDACTED])

32. At some point between 8:30 a.m. to 9:00 a.m., DA1 [REDACTED] and the Staff LPN looked in on the Service Recipient and examined the Service Recipient's left knee. The Staff LPN touched the Service Recipient's left knee. DA1 [REDACTED] and the Staff LPN observed the Service Recipient's left knee to appear "a little out of sorts ... like it had moved out of joint." (Hearing testimony of DA1 [REDACTED]) DA1 [REDACTED] observed a large lump. Based on their observations, DA1 [REDACTED] and the Staff LPN decided to send the Service Recipient to the hospital. (Justice Center Exhibits 10 and 11, and Hearing testimony of DA1 [REDACTED])

33. Sometime after 11:00 a.m., the Service Recipient was examined at the hospital and diagnosed with a dislocated left knee. (Justice Center Exhibit 42)

34. The Subjects' use of first aid (ice) and PRN Tylenol to relieve the Service Recipient's knee pain on [REDACTED] was the same treatment that the Subjects had employed to relieve the Service Recipient's knee pain in the time period between the Service Recipient's knee dislocation on [REDACTED] and [REDACTED]. (Hearing testimony of Subject [REDACTED])

### 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 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, which is defined as follows:

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 details of the events of [REDACTED] and [REDACTED] were not disputed in the hearing.

Instead, the Justice Center contends that the Subjects committed neglect by failing to follow the OPWDD policies that were in effect at the time of the alleged neglect. The Justice Center argues that the policies required that the [REDACTED] direct care staff call the on-call Registered Nurse (RN)<sup>6</sup> upon any change in health status of a service recipient, including any indication of pain by a service recipient. In support of its contention, the Justice Center cites the [REDACTED] Policy No. 5.7, which provides, in relevant part, that “Any changes in health status will be reported immediately to supervising Registered Nurse (RN)/RN-On-Call.” The policy further states that the on-call RN should be called immediately when a direct care staff “Observes changes in an individual’s health status ...” (Justice Center Exhibit 29) The Justice Center also cites the Office of Mental Retardation and Developmental Disabilities Administrative Memorandum (OMRDDAM) - #2008-01 which provides in relevant part “the RN on-call will be immediately notified ... of changes in a consumer’s health status.” (Justice Center Exhibit 30)

The Subjects collectively contend that they were authorized to use basic first aid (in the form of an icepack) and to administer one dose of PRN medication to the Service Recipient without calling the on-call RN. The Subjects further contend that, in the event that neither the first aid nor the PRN medication alleviates the pain or discomfort after one hour, or if a second dose of PRN medication is required in the same day, then they were required to call the on-call RN. The Subjects argue that on [REDACTED], first aid and/or PRN medication was administered each of the three times that the Service Recipient indicated that she was

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<sup>6</sup> Because [REDACTED] was a Sunday and [REDACTED] was the [REDACTED] Holiday, there was no regular RN on duty either day, necessitating the use of an on-call RN in the event RN services were required.

experiencing knee pain or discomfort, and each time the first aid or PRN medication was administered, the Service Recipient's pain and/or discomfort was relieved within one hour, thereby obviating the requirement to call the on-call RN.

In support of their contention, the Subjects cite the PONS, which was prepared as a result of the Service Recipient's knee injury and which specifically addresses the care of the Service Recipient concerning her knee injury. The PONS states, in relevant part, that "Staff will contact RN if: -Pain is not relieved in one hour after PRN pain medication is given." (Justice Center Exhibit 46) The Subjects also cite, in support of their contention, the Policy No. 6.6 concerning the administration of PRN medication by staff. Policy No. 6.6 states, in relevant part, that "Approved Medication Administration Personnel (AMAP) may administer one dose of a PRN (as needed) medication without prior RN approval ... Administration of a second dose, within the same day, by an AMAP would require notification of the supervising RN/RN On-Call." (Subjects Exhibit 1) The record reflects that Subject, who administered the PRN Tylenol to the Service Recipient, was AMAP certified at the time. (Hearing testimony of Subject) The record also reflects that the use of ice applied to the Service Recipient's knee is basic first aid (the least invasive treatment) and was taught as part of the AMAP certification. (Hearing testimony of) Finally, there is evidence in the record that the Subjects were discouraged from calling the on-call RN because of the cost to the state incurred by making such a call. (Justice Center Exhibit 47: Justice Center interrogation of Subject and Hearing testimony of Subject)

To prove neglect, the Justice Center must first establish that the Subjects' conduct breached their custodian's duty to the Service Recipient. (SSL § 488(1)(h)) The Justice Center argues that the Subjects had the duty to call the on-call RN when the Service Recipient indicated

that she was experiencing pain or discomfort. The Justice Center bases this argument on its contention that facility policy requires direct care staff to call the on-call RN upon any change in health status of the Service. (Justice Center Exhibits 29, 30 and 33) Although these policies cited by the Justice Center state this as a general principle, only one of the policies provides any guidance in determining what would qualify as a “change in health status.”

The [REDACTED] Policy [REDACTED] only states that “... staff are to respond according to their training” (Justice Center Exhibit 29), and the OMRDDMA #2008-01 is silent on the matter. (Justice Center Exhibit 30)

Only the Health Care Protocol for NON-EMERGENCY SITUATIONS (HCPNES) provides a list of conditions for which direct care staff should call the on-call RN. Among the conditions included in the list is “Signs/symptoms of pain.” Stated in the protocol, preceding the list is a directive that [REDACTED] direct care staff “Note changes in health status that are unusual for that person, and respond according to training.” (Justice Center Exhibit 33)

While the HCPNES provides some guidance for determining what constitutes a “change in health status” and when to call the on-call RN, it is not unequivocal. A much clearer directive which specifically addresses the Service Recipient’s health care, was provided directly to all of the Subjects and other direct care staff at the [REDACTED], in the form of the PONS. The PONS provided direct care staff with specific directions concerning the Service Recipient’s health care and, specifically, concerning the care of her left knee after the [REDACTED] dislocation. The PONS states, in relevant part, that “Staff will: -Administer medications as prescribed for pain” and “Observe for and administer PRN medications for pain/discomfort as ordered.” Specifically concerning the issue of when to call the on-call RN, the PONS states “Staff will contact RN if: - Pain is not relieved in one hour after PRN pain medication is given.” (Justice Center Exhibit 46)

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The PONS provided the Subjects and other █████ direct care staff the most specific and unequivocal directions and guidance concerning the Service Recipient's health care and, specifically, circumstances which require a call to the on-call RN. The PONS was posted in the █████, and the Subjects and other █████ direct care staff were required to review and follow it.

The OMRDDMA #2008-01 makes it the responsibility of the RN to develop a PONS. The OMRDDMA #2008-01 further provides that "It shall be the responsibility of the RN to exercise professional judgment in determining which nursing procedures unlicensed direct care staff will be allowed to perform, and which unlicensed staff will be allowed to perform them." (Justice Center Exhibit 30) The █████ RN issued such guidelines to the █████ direct care staff in the form of the PONS, and the PONS clearly gives authority to the █████ staff to administer one dose of PRN medication for pain or discomfort without calling the on-call RN. Furthermore, the PONS only requires the █████ direct care staff to call the on-call RN in the event that the Service Recipient's pain or discomfort is not relieved after one hour. (Justice Center Exhibit 46) This policy outlined in the PONS is supported by the █████ Policy █████ which states, in relevant part, "Approved Medication Administration Personnel (AMAP) may administer one dose of a PRN (as needed) medication without prior RN approval ... Administration of a second dose, within the same day, by an AMAP would require notification of the supervising RN/RN On-Call." (Subjects Exhibit 1)

The PONS is the most specific and unequivocal policy, and the only policy in the record that is focused directly on the Service Recipient's care and, more specifically, the care of the Service Recipient's injured left knee. The other policies are general in nature and appear to be meant for generic guidance. Considering the various policies in evidence, the only logical and reasonable interpretation that can be made is that the PONS was the controlling document

concerning the Service Recipient's care and, as such, the PONS did not require staff to call the on-call RN for the Service Recipient's pain or discomfort that was relieved within one hour after administration of PRN medication.

On , the Service Recipient indicated three times that she was experiencing pain or discomfort. The first instance occurred before brunch when the Service Recipient pointed to her left knee and then responded affirmatively when asked by Subject if her knee hurt. The second instance occurred about one hour later, after the Service Recipient ate brunch, when she started whining. The Service Recipient responded affirmatively when she was asked by staff if her knee hurt and again when she was asked by staff if her head hurt. (Hearing testimony of Subjects ) The third instance occurred in the evening at some point between 8:00 p.m. and 8:30 p.m. when the Service Recipient started to cry after having been put in bed. When asked by Subject if she wanted ice for her knee, the Service Recipient responded affirmatively. (Hearing testimonies of Subjects ) Other than these three instances, there is no evidence in the record of the Service Recipient complaining of or experiencing pain or discomfort in her knee or elsewhere on her body at any other point in time between at 7:00 a.m. and at 11:01 a.m., when she was admitted to the hospital.

Upon the first instance of the Service Recipient indicating knee pain (before brunch), Subjects and DSA all examined the Service Recipient's left knee and determined that there was no change in how the Service Recipient's knee normally appeared after the injury. The three direct care staff decided, as a precautionary measure, to use basic first aid, in the form of an icepack applied to the Service Recipient's knee, to relieve any discomfort she may have been experiencing.



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the Service Recipient PRN Tylenol as directed in the PONS. In each case the Service Recipient's pain or discomfort was relieved within less than an hour after the treatment. The Subjects' conduct followed the requirements of their AMAP certification and the PONS and, therefore, did not breach their custodian's duty.

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

**DECISION:**

The request of ██████████ that the substantiated report dated ██████████ be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

The request of ██████████ that the substantiated report dated ██████████ be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

The request of ██████████ that the substantiated report dated ██████████ be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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The request of ██████████ that the substantiated report dated ██████████ be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

The request of ██████████ that the substantiated report dated ██████████ ██████████ be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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

**DATED:** April 28, 2016  
Schenectady, New York



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John T. Nasci, ALJ