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

In the Matter of the Appeal of [redacted] Pursuant to § 494 of the Social Services Law	**FINAL DETERMINATION AFTER HEARING** **Adjud. Case #:** [redacted]

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

[redacted]

By: Tracy S. Harrienger, Esq.
1219 North Forest Road
Williamsville, NY 14231

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

ORDERED: The subject, [redacted] has not been shown by a preponderance of the evidence to have committed abuse and/or neglect as contained in the substantiated report [redacted].

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: Schenectady, New York
September 9, 2014

David Molik
Administrative Hearings Bureau

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

In the Matter of the Appeal of [redacted] Pursuant to § 494 of the Social Services Law	**RECOMMENDED DECISION AFTER HEARING** **Adjud. Case #:** [redacted]

Before: Gerard D. Serlin
Administrative Law Judge

Held at: West Seneca DDSO
1200 East and West Road
Building 16
West Seneca, NY 14224
On: [redacted]

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

[redacted]
[redacted]
[redacted]
By: Tracy S. Harrienger, Esq.
1219 North Forest Road
Williamsville, NY 14231

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted]. for abuse and/or neglect. [redacted] requested that the VPCR amend the report to reflect that [redacted]. is not a subject of a Category 4 substantiated report. The Justice Center 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" Category 4 report [redacted] of neglect by [redacted] of a service recipient, [redacted]

2. The initial report alleges, in pertinent part, that:

> [redacted], at the [redacted], located at [redacted] a staff member, neglected [redacted] when, upon returning from a hospital visit at which [redacted] was diagnosed with a compression fracture of T11 following a fall at the facility. [The staff] failed to properly review and report to [other staff] at the facility and provider agency the symptoms that would warrant seeking immediate medical care for [redacted] were he to experience them. When [redacted] developed those symptoms in the presence of [the staff members], [staff] failed to seek such medical attention for him.

3. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).

4. On or about [redacted] the Justice Center substantiated the report against [redacted] as a Category 4 offense. The Justice Center concluded that:

> [T]hese allegations have been substantiated as a Category 4 case of Neglect against [redacted] This finding is based on the failure of the [redacted] to have policies in place: (1) for nursing staff to assess a client upon returning to the house after the nurse has left for the day, and (2) for staff to

> review medical discharge paperwork or debrief staff on what to look for or how to respond should the service recipient decline in health upon return from a hospital discharge. Failure to have these policies in place exposed [redacted] to harm or risk of harm, but any culpability of nursing staff or other facility staff who were not informed of the discharge instructions is mitigated by this failure. Based on these findings, this case is being referred to the Office for People with Developmental Disabilities and the Justice Center's Oversight and Monitoring Unit to monitor that appropriate corrective actions have been put in place.

The report was also substantiated against an individual who was a custodian of the service recipient and who was under the employ of [redacted]. The other substantiated subject is referred to throughout this decision as the "Custodian-Subject." This decision shall have no impact upon the disclosure of, or retention of this substantiated report as it pertains to any other substantiated subject, with the exception of [redacted]

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

6. At the time of the alleged neglect, the Custodian-Subject was employed by [redacted]. At the time of the report, [redacted], the service recipient, resided in the [redacted] operated by [redacted]. [redacted] is an agency or provider that is subject to the jurisdiction of the Justice Center.

7. The alleged maltreated service recipient, [redacted] is a male, who was approximately 61 years of age at the time of the incident at issue. [redacted] is a person who walks with the assistance of a gait belt and has a history of seizure disorder. [redacted] was often evaluated at the hospital for seizure activity. Following hospital treatment for seizure activity, [redacted] historic demeanor was frequently lethargy, particularly in the hours and the morning following a hospital visit. (Justice Center Exh.7, recorded interview with [redacted])

8. On or about [redacted], at approximately 7:30 p.m., [redacted] fell while toileting[1] at the [redacted] A staff member at the [redacted] (the Custodian-Subject), called [redacted], the [redacted] on-call Registered Nurse (RN), on the telephone at 7:26 p.m. and reported that [redacted] fell off the toilet, hit his head, and had sustained a small bump but had no perfuse bleeding. The RN and the Custodian-Subject discussed a three day head-injury follow up evaluation and then concluded the phone call. At 7:32 p.m. (six minutes later), the Custodian-Subject called the RN and stated that [redacted] could not move from the floor and complained of back pain. The nurse instructed the Custodian-Subject to call 911. [redacted] was transported by ambulance to the hospital for evaluation. The Custodian-Subject left the [redacted] to accompany [redacted] to the hospital.

9. While at the hospital, [redacted] received a CAT scan.[2] In any event, the medical evaluation revealed a "compression" fracture of T-11. (Justice Center Exh. 7: interview with Custodian-Subject[3]) While at the hospital, [redacted] "legs were not supporting him completely." (Justice Center Exh. 4 - letter addressed to the VPCR and authored by the Custodian-Subject on or about [redacted])

10. [redacted] was released from the hospital without admission with orders to follow up as soon as possible with an orthopedist. The Custodian-Subject was provided with general *discharge instructions* which included the warning to: "Seek immediate medical care if … numbness, tingling, weakness or problems with the use of … arms or legs [developed]." (Justice Center Exh. 9 p.5) Medical staff advised the Custodian-Subject, that [redacted] "might" be

[1] The mechanics and or the specifics of [redacted] fall were not well developed in the record. There was speculation in the record that [redacted] lost balance while sitting on the toilet, while attempting to adjust his position. The fall was unwitnessed, as [redacted] employee [redacted] had her back to [redacted] at the time of the fall. (Justice Center Exh. 12) The Justice Center did not substantiate the case based on the fall. However, the mechanics of the fall do play in to the overall analysis of this case.

[2] It was never clear if the CAT scan was conducted on [redacted] vertebrae, head or both. See footnote 7.

[3] The physician was uncertain if the fracture was the result of, or pre-dated, the toileting fall. (Justice Center Exh. 9 P.6)

ambulatory. A doctor advised the Custodian-Subject that a compression fracture of the T-11 would "probably" not negatively impact [redacted] ability to ambulate. (Justice Center Exh. 7: interview with Custodian-Subject)

11. Later in the evening, between 11:00 p.m. and 11:30 p.m., the Custodian-Subject returned to the [redacted] with [redacted] [redacted] staff members, [redacted] and [redacted], greeted the Custodian-Subject and [redacted] in the driveway and offered their assistance with moving [redacted] from the van. However, the Custodian-Subject indicated that he did not need assistance. (Justice Center Exh.7, interview with [redacted]) [redacted] was transported from the van to the residence via wheel chair.[4]

12. Once inside the residence, [redacted] went to the kitchen where the Custodian-Subject assisted [redacted] with eating.[5] The Custodian-Subject fed [redacted] ice cream. [redacted] may have experienced some problem using his "arms" or hand,[6] but the Custodian-Subject attributed this to [redacted] being tired from the hospital visit and pain from the injuries which [redacted] sustained during the fall. As a result of the fall, [redacted] sustained a head laceration, or hematoma, and abrasions to the front of each knee, the right ankle, top of the right wrist, both

[4] The investigative record was un-developed on the issue of how often [redacted] used a wheel chair before this fall. The only clear evidence in the record was that [redacted] walked with assistance of a gait belt. Sometimes, [redacted] would use a wheel chair, but there was no evidence regarding circumstances which would precipitate the need for a wheel chair. Additionally [redacted] had a "standing lift" which is a device that was sometimes used to lift [redacted] from a seated position, to a standing position, or from one seat to another seat. However, the record was likewise unclear as to when, or under what circumstances [redacted] required the assistance of the "standing lift." (Justice Center Exh.7, recorded interview with [redacted]) [redacted] had previous falls outside of the bathroom and in the two years preceding this incident, [redacted] ability to ambulate had declined. (Justice Center Exh.7, recorded interview with [redacted])

[5] The investigative record was un-developed as to whether [redacted] had ever, or routinely required assistance with eating. [redacted] indicated that she was unfamiliar with the level of [redacted] ability to feed himself, except that she once saw [redacted] "eating a couple mouthfuls of cereal" without assistance. Staff [redacted] denied any familiarity with [redacted] ability to feed himself. (Agency Exh. 7, recorded interview with [redacted])

[6] The problem or problems observed by the Custodian- Subject with [redacted]s "arms," were not well developed during the interview with the Custodian-Subject. Staff [redacted] told the [redacted] investigator that the Custodian-Subject indicated to her that [redacted] was having some problem with his right arm and possibly his hand. (Agency Exh. 7, recorded interview with [redacted])

elbows, as well as a mid-back scratch and bruise. (Justice Center Exh.13[7]) Also present in the kitchen were [redacted] staff [redacted]. The Custodian-Subject conveyed to [redacted] co-staff [redacted] and [redacted] that [redacted] had a CAT scan while at the hospital and it was "negative." The Custodian-Subject did not show [redacted] or [redacted] the *discharge instructions*.

13. [redacted] staff [redacted] asked [redacted] if he wanted to go into the living room to watch the remainder of the football game on the television. [redacted] cognitive behavior was not out of the norm, and he responded "yes" he would like to watch the game. (Justice Center Exh.7, recorded interview with [redacted]) [redacted] then watched the remainder of the football game in the living room.

14. The Custodian-Subject left the kitchen to complete paperwork. The Custodian-Subject failed to read that, within the *discharge instructions,* there was included a general warning that immediate medical care should be obtained if the patient develops "numbness, tingling, weakness, or problems with the use of … arms or legs." (Justice Center Exh. 9 p. 5) The Custodian-Subject also failed to note the existence of *discharge instructions* in the "Therap log." (Justice Center Exh. 11, Therap notes)

15. When the football game ended, staff members [redacted] and [redacted] assisted [redacted] with getting situated for bed. The staff members were unable to get [redacted] into bed by themselves as his gait was unsteady. [redacted] experienced some inability to support his weight and said "ouch-ouch." [redacted] assumed there was some issue with [redacted] legs and asked [redacted] to wiggle his toes, which he did successfully. (Justice Center Exh. 7, recorded interview with [redacted]) [redacted] sometimes needed assistance with getting into bed. (Justice Center Exh.7, recorded interview with [redacted])

[7] No medical records of the hospital visit on the evening of [redacted] were made part of the record. The report (Justice Center Exh. 13), chronicling the injuries sustained by [redacted] as a result of the fall was completed by [redacted] staff the morning following the incident.

16. [redacted] was then lowered to the ground bed-side. (Justice Center Exh. 7, recorded interview with [redacted]) The staff then alerted the Custodian-Subject and asked for assistance in getting [redacted] into bed. The Custodian-Subject arrived then assisted co-staff members with moving [redacted] into the bed.

17. At approximately 11:31 p.m., after assisting [redacted] to bed, the Custodian-Subject phoned the on-call RN, [redacted], and disclosed the diagnosis of a possible fracture of the T-11 and that hospital staff told him to follow up with [redacted] Spine Center. (Justice Center Exh. 7, recorded interview with [redacted], RN)

18. The RN did not discuss the signs and symptoms related to follow up of T-11 diagnosis and did not specifically ask the Custodian-Subject if he wanted an outline of "what to look for," in terms of possible complications. However, RN [redacted] would not have, without actually reviewing the *discharge instructions* have been able to provide a comprehensive overview of what to look for in terms of signs or symptoms consistent with complications resulting from the T-11 fracture diagnosis. RN [redacted] asked the Custodian-Subject only if there were physician "Orders," to which the Custodian-Subject replied that there were not. (Justice Center Exh. 7, recorded interview with [redacted], RN)

19. During the phone conversation with the RN, the Custodian-Subject did not disclose that any "limpness" was noted in [redacted] Nonetheless, the RN did recommend that [redacted] be assisted in walking. The Custodian-Subject did disclose to the RN that [redacted] did complain of pain "in that area."[8] The RN recommended an over counter pain medicine because there was no hospital directive on pain. (Justice Center Exh. 7, recorded interview with [redacted] RN)

[8] The investigative record was undeveloped as to the area of his body where [redacted] was experiencing pain.

20. During the overnight, [redacted] typically had his diapers changed every two hours. However, [redacted] remained dry during the overnight, never complained of pain and never awoke during 15 minute interval bed checks. During the overnight [redacted] was observed to be "more stretched out" in bed, than was normal for him. (Justice Center Exh. 7, recorded interview with [redacted])

21. At about 5 a.m., [redacted] diapers were changed by use of a log roll. (Justice Center Exh. 7, recorded interview with [redacted]) At 5:30 a.m., [redacted] *Day Aid,* [redacted] who had received a text message that [redacted] had fallen the night before, arrived at the [redacted] to review the hospital *discharge instructions*. (Justice Center Exh.7, recorded interview with [redacted]) The *discharge instructions* had been left in the office on the supervisor's desk by the Custodian-Subject the evening before. (Justice Center Exhh.7, recorded interview with Custodian-Subject) At approximately 6:10 a.m., [redacted] went into [redacted] room with [redacted] *Staff Developmental Specialist*. [redacted] legs were hanging off the end of bed. The staff had to "re-adjust" [redacted] legs. The staff then assisted [redacted] in sitting up, which was atypical. [redacted] normally could swing legs over the bed and pull himself up. (Justice Center Exh.7, recorded interview with [redacted])

22. The staff then helped [redacted] stand up with his gait belt. [redacted] would normally walk along the railing of his bed. This morning however, [redacted] appeared unable to support his weight. [redacted] was normally talkative and social, but not this morning. Staff then assisted [redacted] in getting back into bed. [redacted] reached her hand out to [redacted] and asked him to shake her hand. [redacted] was historically an avid hand-shaker.

23. [redacted] left arm appeared weak. [redacted] then grasped [redacted] left hand and noted that [redacted] kept dropping his left arm and the arm "was droopy [with no] muscle

tone." At this time, the on–site LPN appeared in the room, evaluated [redacted] and concluded that [redacted] needed to return to the hospital. [redacted] also called RN [redacted] on the phone, and advised that there was left sided weakness[9] and [redacted] had "stroke" like symptoms. Nurse [redacted] advised that [redacted] should go to a hospital. [redacted] was transported by ambulance to [redacted] Hospital. The decision to transport to [redacted] Hospital[10] was on the advice of EMTs who noted "stroke like" symptoms in [redacted] (Justice Center Exh.7, recorded interview with [redacted])

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse or neglect.
- Pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse or neglect in residential care facilities. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse or neglect presently under review was substantiated. A "substantiated report" means a report made "… if an investigation determines that a preponderance of evidence of the alleged neglect and/or abuse exists."

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[9] See footnote 3; the evening prior there was some issue with the right side of [redacted] body as reported by staff member [redacted] as reported to her by the Custodian-Subject. However, during his interview with the Justice Center investigator, the Custodian-Subject reported some issue with the Subject's "arms" during the evening of the fall after release from the hospital, see footnote 4. However, the on-site LPN who evaluated [redacted] the morning after the fall noted in the Therap Log that was experiencing right-sided weakness but made no mention of left-sided issues. (Justice Center Exh. 11)

[10] On the evening of the fall, [redacted] was treated at a [redacted] Hospital.

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: 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, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse or neglect; and pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

The abuse and neglect of a person in residential care is defined by SSL § 488:

1. "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:

    (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

    (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

    (c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct

may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a

controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the subject committed the act or acts of abuse or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category level of abuse and neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

(a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

(i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;
(ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;
(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;
(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;
(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;
(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;
(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;
(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;
(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;
(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and
(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(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.

(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.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse, 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 cited in the substantiated report constitutes the category level of abuse set forth in the substantiated report.

If the Justice Center did not prove the abuse by a preponderance of evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has not established by a preponderance of evidence that the Subject [redacted] has committed Category 4 Neglect as is alleged in the substantiated report.

At the conclusion of the investigation, the Justice Center took the position that [redacted].:

> … [Failed] … to have policies in place: (1) for nursing staff to assess a client upon returning to the house after the nurse has left for the day, and (2) for staff to review medical discharge paperwork or debrief staff on what to look for or how to respond should the service recipient decline in health upon return from a hospital discharge. Failure to have these policies in place exposed [redacted] to harm or risk of harm, but any culpability of nursing staff or other facility staff who were not informed of the discharge instructions is mitigated by this failure…

The Justice Center relied on Social Services Law § 493 (4)(d) to substantiate this case as a Category 4 offense. Counsel for [redacted] argued that before the Justice Center could establish a Category 4 finding against [redacted] under Social Services Law § 493(4)(d), the Justice Center was first required to prove that a custodian, even if that custodian could not be identified, committed an act which would constitute abuse or neglect pursuant to Social Service Law § 488. Stated another way, counsel for [redacted] argued that § 493(4)(d) merely defines a Category 4 offense, but does not define the custodial conduct rising to the level of abuse or neglect and that a finding of same, is a condition precedent to a Category 4 finding under Social Services Law § 493 (4)(d).

The Justice Center countered, that proof by a preponderance, that a facility or provider has violated Social Services Law § 493 (4)(d) is sufficient for a Category 4 finding, even in the absence of proof by a preponderance, that a custodian under employ or supervision of a facility or provider committed abuse or neglect as that term is so defined in Social Services Law § 488.

The ALJ presiding over the hearing defers to the Justice Center's interpretation of the applicable statute herein. But in any event in this case as subsequently discussed the argument is not pivotal in the outcome of this hearing.

The Justice Center also argued in the alternative, that in this case the Justice Center had established by preponderance that a custodian committed an act of neglect under Social Services § 488; the specific violation was alleged to have occurred under Social Services Law § 488 (h), which states in relevant part:

> "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: … 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…

Counsel for [redacted] argued that there was no proof in the record that a custodian (in this case the Custodian-Subject), had committed Medical Neglect under Social Services Law § 488 (h)(ii), or any form of Neglect under Social Services Law § 488. Counsel argued that there is no proof in the record that a custodian failed to provide adequate medical care consistent with the rules or regulations promulgated by the state agency operating the [redacted] as required by SSL 488 (h)(ii). Indeed, at the hearing it was stipulated on the record that there was no

violation of a rule or regulation promulgated by a state agency operating the [redacted], as required by SSL § 488(h)(ii). Therefore, Social Services Law § 488 (h): Medical Neglect is not a viable theory in this case.

[redacted] also argued that there is no proof in the record that a custodian'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 as is required under Social Services Law § 488 (1)(a): Physical abuse. For the reasons stated infra, it is not necessary to address the legal argument that the Justice Center must prove a violation of Social Services Law § 488 as a condition precedent to a Category 4 finding.

[redacted] argued that polices already in existence shield the entity from a finding of a Category 4 violation under SSL § 493(4)(d). Counsel for [redacted] introduced [redacted] *Residential Department Medical Appointments Policy and Procedure*. ([redacted] Exh. A). The Justice Center introduced [redacted] *Emergency Medical Policy & Procedure*. (Justice Center Exh. 10) Counsel for [redacted] argued that these polices meet the minimum requirements for addressing a situation such as the one presented in this case and that [redacted] *Emergency Medical Policy & Procedure*: (Justice Center Exh 10) was created as a result of an Administrative Memorandum issued by OMRDD in 2003.[11] [redacted] took the position that these polices fully comply with the OMRDD Administrative Memorandum; therefore, as a matter of law, [redacted] cannot be found to have committed a Category 4 violation.

The necessity of OMRDD Administrative Memorandum # 2003-01 can be traced to New York Education Law § 6908(1)(b). The intention of New York Education Law § 6908(1) was clearly to exempt service providers under the employ of facilities like the [redacted] who routinely perform certain health care functions for service recipients, from the requirement that

[11] See OMRDD Administrative Memorandum # 2003-01 ([redacted] Exh. B)

that the providers be Licensed Practical Nurses. It is equally clear that the purpose of *OMRDD Administrative Memorandum # 2003-01* was to insure that the service providers, who do perform functions which would normally fall within the scope of practice of a Licensed Practical Nurse, are properly supervised by a Registered Nurse.

In this case, whatever omission or failure the Custodian-Subject engaged in does not fall within the scope of practice of a Licensed Practical Nurse[12] and therefore *OMRDD Administrative Memorandum # 2003-01* does not establish minimum standards for [redacted] policies, under the facts of this case. The situation as presented is truly about proper protocol for assessing when emergency health care should be sought, proper communication between service provider staff and health care professionals and appropriate follow up care. This case is not about the supervision of employees performing health care tasks which would generally be considered to be within the scope of practice of a Licensed Practical Nurse.

Indeed, the two policies of [redacted] which appear in the record also address protocol for assessing when emergency health care should be sought, proper communication between service provider staff and health care professionals and appropriate health care follow up. The Justice Center argues however that the two polices do not go far enough to ensure the well-being of service recipients and in any event, the Custodian-Subject employee did not follow these policies because of poor training and systemic supervision failures on the part of [redacted]

There was some evidence in the record that the Custodian-Subject violated [redacted] *Emergency Medical Policy & Procedur*e[13] in that the Custodian-Subject failed to:

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[12] NY EDUCATION LAW § 6902 (2): The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case[-]finding, health teaching, health counseling, and provision of supportive or restorative care under the direction of a registered nurse … or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations.

[13] See Justice Center Exh. 10 p.3

> [b]efore leaving the Emergency Room, …ensure that …[staff] have a complete summary of what took place at the Emergency Room. If the discharging physician is unwilling to complete the [redacted] Physician's Notes and Orders form, the staff must ensure that the facility provides comprehensive discharge information/paperwork.

However, absence of medical records and/or interviews with medical staff renders such a conclusion speculative. The Physician's Notes and Orders form states only the diagnosis of a T-11 fracture coupled with a conclusion that the age of fracture is unknown.

There was no convincing evidence that the Custodian-Subject actually failed to verify "medication/treatment orders with site RN and /or on Call RN."[14] Clearly the Custodian-Subject either failed to read the warning: "Seek immediate medical care if … numbness, tingling, weakness or problems with the use of … arms or legs...." develops. (Justice Center Exh. 9 p.5) The Justice Center correctly recognized that the phone conversation between RN [redacted] and the Custodian-Subject was less than productive. Nurse [redacted] told the internal [redacted] investigator that she asked the Custodian-Subject subject if there were any physician "*Orders*" to which he replied, that there were none. (Justice Center Exh. 7, recorded interview with [redacted] RN)

RN [redacted] indicated that her use of the word "*Orders*" may have confused the Custodian-Subject because the *discharge instructions* did not contain the word "*Order(s).*" Indeed, the instructions contain a section on the front page entitled: "Follow-up instructions," but there are no warnings about "numbness, tingling or weakness" in this section of the *discharge instructions*. The warning regarding those symptoms actually appears on the fifth page of the instructions. (Justice Center Exh. 9 p. 5) RN [redacted] used the term "*Orders*" during her conversation with the Custodian-Subject and did so, most likely because the term "*Orders*" is used in the relevant [redacted] policies: *Emergency Medical Policy & Procedure:* and

[14] See facts numbered 10, 12 and 17 herein.

Residential Department Medical Appointment Policy and Procedure. ([redacted] Exh. A.[15] and Justice Center Exh. 10 p.3,[16] respectively)

The Justice Center took the position that [redacted] should have adopted a policy whereby the *On-Call* RN actually reviewed the *discharge instructions* immediately upon discharge rather than relying upon [redacted] staff to relay the contents of the instructions. Indeed, such a policy may have resulted in the discovery of the instructions regarding numbness, tingling and or weakness of appendages. However, as counsel [redacted] noted at hearing, there is simply no evidence in the record to illustrate that [redacted] had systemic problems such as inadequate management, staffing, training or supervision. Additionally, Counsel for [redacted] argued that there is no evidence in the record that the service recipient suffered harm or risk of harm as is required by Social Services Law § 493(4)(d).

There is no convincing evidence in the record that Custodian-Subject was improperly trained on the relevant policies. The Justice Center points to a statement in the record made to the [redacted] investigator by staff [redacted] essentially stating that the Custodian-Subject did not share the *discharge instructions* with her, and she would not have expected him to. (Justice Center Exh. 7, Recorded interview with [redacted] The Custodian-Subject conveyed only to [redacted] co-staff Moline and [redacted] that [redacted] had a CAT scan while at the hospital and it was "negative." However, the relevant policies don't specifically require that the *discharge*

[15] The pertinent section of the policy states that:

> Before leaving the Emergency Room, the staff member must ensure that they have a complete summary of what took place at the Emergency Room. If the discharging physician is unwilling to complete the [redacted] Physician's Notes and Orders form, the staff must ensure that the facility provides comprehensive discharge information / paperwork.

[16] The pertinent section of the policy states that:

> Upon return to the Residence the Staff member whom attended the medical appointments has the following obligations: … Verifies medication/treatment orders with site RN and /or on Call RN.

instructions be shared with co-staff but instead that the RN is consulted,[17] that a Supervisor be notified and that notations regarding same are made in THERAP log.

As is addressed in detail previously in this decision, [redacted] had policies in place which, if followed by the Custodian-Subject, may have avoided the delayed response, if in fact there was actually a reason to respond sooner than the morning following the fall.

However, there is sparse evidence in the record that the service recipient's limitations on the evening of [redacted] were a change from his baseline. Even if RN [redacted] had examined the service recipient immediately upon returning to the [redacted] or had reviewed the *discharge instructions* on the evening of discharge, there is no evidence in the record upon which it can be concluded that the service recipient was experiencing *atypical symptoms for him* such as "numbness, tingling, weakness, or problems with the use of …arms or legs." (Justice Center Exh. 9 p. 5) The preponderance of evidence in the record establishes that the service recipient historically suffered from limitations of mobility, and in ambulation, frequent falls - as well as post hospital discharge lethargy. While much was made of the fact that the Custodian-Subject assisted the service recipient with eating on the evening of [redacted], proof that the service recipient routinely and historically fed him-self without assistance, is conspicuously absent from the record. (See footnote 5 herein)

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[17] The relevant policy, [redacted] *Emergency Medical Policy & Procedure* (Justice Center Exh. 10 p.3), places the obligation on RN staff to follow up the day after a night time (RN- On-Call hours), emergency department visit:

> If the visit occurred during RN On-Call hours, the On-Call RN is responsible for notifying the primary RN by the next working day. This may be accomplished via phone call or Therap T-Log ER alert. The RN will follow-up with the situation and ensure that individual receives all follow-up care required. The RN will review the situation and determine if the individual was properly safeguarded.
>
> The RN will check any new orders including medication changes to ensure that the order was correctly implemented. The RN will ensure that the Physicians Order Book contains the copy of the prescription and medication information sheet in accordance with the Physician's Order Book Policy.

It would be speculative to conclude that the service recipient presented with symptoms which were atypical for him or could reasonably be defined as "numbness, tingling or weakness," or other atypical problems with the use of his appendages, during the period of time between his hospital discharge and when he went to sleep. It is simply not possible, without baseline proof of the service recipient's normal functioning level, to conclude that the service recipient's behavior during the 90 minute period which he was awake while at the [redacted] on the evening of [redacted], illustrates that he experienced "numbness, tingling, weakness, or problems with the use of …arms or legs", which were out-side of his normal limitations. (Justice Center Exh. 9 p.5)

Even assuming for the sake of argument that the service recipient deteriorated after the fall, or as a result of the fall, or even perhaps while in the hospital, there is no evidence in the record to determine whether or not the condition of the service recipient at the time of his first hospital visit, on the evening of the [redacted], was evaluated by hospital staff, and determined to be benign and related to the fall. The Custodian-Subject claimed that while at the hospital, [redacted] "legs were not supporting him completely" and, as is well developed in the record, the service recipient had pronounced deficits with ambulation generally. (Justice Center Exh. 4 - letter addressed to the VPCR and authored by the Custodian-Subject on or about [redacted])

Unlike the record pertaining to the evening of [redacted], the record of the symptoms which the service recipient exhibited on the morning of [redacted] are well-developed and illustrate a marked change from the service recipient's norm.[18] However, it is not clear from the record whether these symptoms were the result of the T-11 fracture, or instead resulted from a misdiagnosis or failure to diagnosis on the evening of [redacted], or if

[18] See paragraphs numbered 21, 22 and 23 herein.

the symptoms were a result of the presentation of a completely independent and new medical condition. It is not possible from the evidence in the record to determine if any medical problem was ever diagnosed with the service recipient after his re-admission to the hospital on the morning of [redacted]. Irrespective of this evidentiary void, the presentation of the service recipient's symptoms on the morning of [redacted], resulted in the staff at the [redacted] appropriately seeking medical care.

While one could conclude that the service recipient suffered some neurological event, perhaps a cardio vascular attack or transient ischemic event beginning sometime during the evening of [redacted], there is no proof of same in the record and to render such a medical conclusion would be speculative. Likewise there is no proof that the first hospital, where the service recipient was seen post-fall, did not simply fail to diagnose the beginning of a cardio vascular attack ultimately erroneously releasing the service recipient without admission and treatment. The absence of medical records and/or medical evidence leaves large holes in the record.

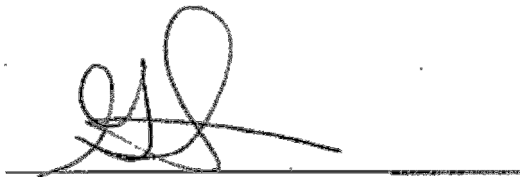
The Justice Center has not proved by a preponderance of the evidence that the facility or provider agency exposed the service recipient to harm or risk of harm where staff culpability was mitigated by systemic problems such as inadequate management, staffing, training or supervision, as required by SSL § 493(4)(d).

Accordingly, it is determined that the Agency has not met its burden of proving by a preponderance of the evidence that [redacted] committed Neglect as a Category 4 violation, and the substantiated report will be amended or sealed.

DECISION: The request of [redacted] that the substantiated report [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed abuse and/or neglect.

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

DATED: Schenectady, New York
August 28, 2014



Gerard D. Serlin, ALJ

ENCLOSED IS THE DECISION FOR YOUR ADMINISTRATIVE HEARING

IF YOU DID NOT WIN YOUR HEARING, YOU MAY APPEAL TO THE COURTS PURSUANT TO THE PROVISIONS OF ARTICLE 78 OF THE CIVIL PRACTICE LAW AND RULES. IF YOU WISH TO APPEAL THIS DECISION, YOU MAY WISH TO SEEK ADVICE FROM THE LEGAL RESOURCES AVAILABLE TO YOU (E.G., YOUR ATTORNEY, COUNTY BAR ASSOCIATION, LEGAL AID, OEO GROUPS, ETC.) SUCH AN APPEAL MUST BE COMMENCED IN STATE SUPREME COURT WITHIN FOUR MONTHS AFTER THE DETERMINATION TO BE REVIEWED BECOMES FINAL AND BINDING. AN APPEAL IS **NOT** COMMENCED BY WRITING TO THIS OFFICE OR ANY OFFICE OR OFFICIAL OF THE NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES, INCLUDING THE STATEWIDE CENTRAL REGISTER OF CHILD ABUSE AND MALTREATMENT.