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]

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.

[redacted]

[redacted]

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 [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized, as a Category 3 act.

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

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

DATED: January 29, 2016
Schenectady, New York

David Molik
Administrative Hearings Unit

`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: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: Western New York DDSO
1200 East and West Road
West Seneca, New York 14224
On: [redacted]

Parties: 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.

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By: Juliane O'Brien, Esq.

[redacted]

[redacted]

JURISDICTION

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

FINDINGS OF FACT

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

1. The VPCR contains a "substantiated" report, dated [redacted], [redacted] of neglect by the Subject of a Service Recipient.

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

Allegation 2

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision to a service recipient by performing his bed checks at two hour intervals instead of the required thirty minute intervals.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect, pursuant to Social Services Law § 493(4)(c).

3. An Administrative Review was conducted and as a result the substantiated report as to Allegation 2 was retained.

4. The facility, known as the [redacted], is located at [redacted]. The [redacted] is a one-story residential facility. There were three male service recipients and one female service recipient

[redacted]

who resided at the facility. (Hearing testimony of [redacted] and Justice Center Exhibit 19) The facility is operated by [redacted] and is certified by the New York State Office for People With Developmental Disabilities (OPWDD), a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject had been employed by [redacted] and assigned to work in the facility as a Residential Trainer for approximately one year prior to the incident. The Subject normally worked the night shift [redacted] (Hearing testimony of the Subject) At the time of the incident, there was a total of two staff persons assigned to work the overnight shift, including the Subject and a "floater" staff member, who also was a Residential Trainer. (Hearing testimony of [redacted] and Hearing testimony of the Subject) The ratio of facility staff to service recipients during the overnight shift was one staff person to two service recipients.

6. Staff assigned to the overnight shift are required, "…to handle problems, carry out security and record keeping duties, programmatic goals, medication administration and routine housekeeping tasks…." (Justice Center Exhibit 19, last page) Additionally, Residential Trainers were required to be trained in safety and security protocols. (Justice Center Exhibit 19)

7. At the time of the alleged neglect, the Service Recipient was sixty-six years of age and had been a resident of the facility at least since 2011. (Justice Center Exhibit 7, page 10) The Service Recipient was an individual diagnosed with cerebral palsy, mild cognitive impairment, type II diabetes, diabetic (foot) neuropathy, anxiety disorder, and obsessive compulsive disorder, among other medical conditions. (Justice Center Exhibits 5, 21 and 26)

8. As of [redacted], the Service Recipient's Individual Plan of Protective Oversight (IPOP), required staff to perform bed checks every 30 minutes when the Service

[redacted]

Recipient was sleeping in his bedroom. (Justice Center Exhibit 22, page 4) The Service Recipient's IPOP listed no exceptions to the 30 minute bed check rule. The staff members were required to document each 30 minute bed check on the Service Recipient's "Safety Checklist" which was kept in the device maintenance book. (Justice Center Exhibit 23)

9. The Service Recipient had an extensive history of falling due to his unsteady gait. Minor Incident Reports and other documents show that in 2013 the Service Recipient had fourteen falls prior to the fall on [redacted]. Two of the falls reportedly occurred on [redacted]. Though his IPOP required "arms-length" staff assistance when the Service Recipient tried to stand or ambulate; the Service Recipient had a well-known history of falling and often asserted his independence by attempting to toilet without calling staff for assistance. The Service Recipient also used a gait belt, walker with wheels and a seat for mobility. (Justice Center Exhibits 19, 20, 21, 22, 34 and Hearing testimony of the Subject) Facility incident reports also showed that the number of falls experienced by the Service Recipient increased dramatically, as he had three documented falls in the month of [redacted], as well as three documented falls in [redacted]. (Justice Center Exhibit 7, page 6)

10. The Service Recipient's safety checklist required that staff was to check on the Service Recipient every 30 minutes when he was sleeping and provide field of vision supervision while the Service Recipient was awake, including 15 minute checks when he was awake in his bedroom. (Justice Center Exhibit 23 and Hearing testimony of Justice Center Investigator [redacted]) This requirement was printed in bold faced letters and underlined on the safety checklist. The requirements were also consistent with the Service Recipient's IPOP, which mandated staff to remain within arm's length of the Service Recipient when he was standing or ambulating. (Justice Center Exhibit 22 and Hearing testimony of Justice Center Investigator [redacted])

[redacted]

11. On [redacted], during the overnight shift, the Subject and the other staff person alternated their assigned work stations between the rear and the front of the house. On that day, because the Subject was the only medication certified staff person at the facility, she began her shift at 12:00 a.m. by performing her medication administration related duties.

12. For most of the remainder of the Subject's overnight shift, the Subject was stationed at the rear of the house where the service recipients' bedrooms were located. The Subject was responsible for providing supervision over the Service Recipient as well as performing other duties such as laundry, cleaning bathrooms, and mopping. (Hearing testimony of the Subject and Justice Center Investigator [redacted]; and Justice Center Exhibits 7 and 34) During this time, the other staff person was working in the front of the house. (Hearing testimony of the Subject)

13. While stationed in the rear of the house, the Subject performed bed checks for the Service Recipient every two hours. The Subject performed bed checks by standing in the doorway of the Service Recipient's bedroom and looking into the room to make sure he was sleeping. The Subject would also glance into the Service Recipient's bedroom from various locations in the rear of the house. (Hearing testimony of the Subject) Because the Service Recipient kept his bedroom door open, the Subject's location in the rear of the house allowed her to see into the Service Recipient's bedroom, to ensure that he was still sleeping in the bed. (Hearing testimony of the Subject)

14. At about 3:00 a.m., the Subject exited a different resident's bedroom at which time she heard the Service Recipient's cry for help through the baby monitor located in the Service Recipient's bedroom. The sound from the baby monitor can be heard throughout the

[redacted]

house. The Service Recipient's bed alarm[1] had not been activated to alert staff that the Service Recipient arose from his bed. (Hearing testimony of the Subject and Justice Center Exhibit 7) Upon entering the bedroom, the Subject found the Service Recipient lying on the floor near the bathroom door. The Subject asked the Service Recipient if he had any pain and he told the Subject that his hip hurt. (Justice Center Exhibit 34, Service Recipient's Interview) Agency protocol required that before making any attempts to move the Service Recipient from the floor, the Subject was to first contact the on-call nurse for directives. (Hearing testimony of the Subject) The on-call nurse told the Subject to take the Service Recipient's vitals, which she had already done, use the hoyer lift to assist the Service Recipient in getting him off of the floor and then make an entry in the Therap Note[2] about the incident. (Hearing testimony of the Subject and Justice Center Investigator [redacted]; and Justice Center Exhibits 15 and 34)

15. The Subject was not successful in using the hoyer device to lift the Service Recipient off of the floor because the hoyer battery was dead. The Subject then called the house manager and asked where the hoyer battery charger was located, but it could not be found. The Subject and staff person [redacted] manually used the seat from the hoyer lift device to lift the Service Recipient from the floor back into his bed. (Hearing testimony of the Subject and Justice Center Exhibit 34, Audio interrogation of [redacted])

16. At about 7:00 a.m. that same morning, staff person [redacted], used the gait belt to help the Service Recipient ambulate to the bathroom. When the Service Recipient took a few steps he stated that his leg hurt. (Justice Center Exhibit 9) After showering the Service Recipient, the other staff person seated the Service Recipient in his wheelchair and gave him

[1] The Service Recipient's bed alarm is weight released activated and set up with a cord which connects to a box on his bed which is plugged into the wall thereby setting off the alarm sound to alert staff when the Service Recipient gets out of bed. (Hearing testimony of [redacted] and Justice Center Exhibit 7, page 9 and Justice Center Exhibit 22, pages 3 and 4)

[2] The "Therap Note" is part of the facility's on-line computer system used for communication purposes between staff members and to track progress. (Hearing testimony of Justice Center Investigator [redacted])

[redacted]

Tylenol. While eating breakfast, the Service Recipient told staff person [redacted] that his leg was hurting in the right calf area. (Justice Center Exhibit 34, Audio interrogation of staff person [redacted]) While staff person [redacted] was re-adjusting the Service Recipient in his wheelchair, the Subject walked by and told staff person [redacted] that the Service Recipient had fallen earlier that morning. (Justice Center Exhibits 9 and 34, Audio interrogation of staff person [redacted]; and Hearing testimony of the Subject)

17. Later that morning at 7:30 a.m., the Subject created a Therap Note, which electronically documented and communicated the incident to staff. (Justice Center Exhibit 15) Thereafter, the Subject also completed a Minor Incident Reporting Form, further detailing the Service Recipient's falling incident. (Justice Center Exhibit 16)

18. Later in the day on [redacted], the Service Recipient was hospitalized and diagnosed with right hip and knee fractures which required surgery. (Justice Center Exhibits 18, 26 - 31) Subsequently, the Service Recipient was transferred to a rehabilitation center. At some later date, the Service Recipient was admitted to the hospital again where he ultimately died. (Hearing testimony of Justice Center Investigator [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 and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

[redacted]

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 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…."

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined in subparagraph (c) 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 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 neglect alleged in the substantiated report that is the subject of the proceeding and that such act or 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

[redacted]

whether the act or acts of neglect cited in the substantiated report constitute 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 the Subject committed a prohibited act or acts of neglect, described as "Allegation 2" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-33) The Justice Center also moved into evidence an audio CD recording. (Justice Center Exhibit 34) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who was the only witness that testified at the hearing on behalf of the Justice Center.

At the hearing, the Subject testified on her own behalf. Additionally, the Subject called as her only witness, [redacted], who was the facility manager at the time of the incident. The Subject provided no other evidence.

The Justice Center's theory of neglect in this case falls under SSL §488(1)(h)(i). The Justice Center alleges that the Subject committed neglect by breaching her custodial duties, when she failed to comply with the Service Recipient's IPOP requiring bed checks every 30 minutes while the Service Recipient was asleep. The Justice Center alleges that the Subject admittedly conducted bed checks at two hour intervals, which resulted in the Service Recipient getting out of bed unsupervised, falling and sustaining right hip and right knee fractures which ultimately required surgery.

[redacted]

In this case, the relevant facts are largely not in dispute and are contained in the record. The Subject was a custodian of the Service Recipient by virtue of her employment as a Residential Trainer at the facility. The Subject testified at the hearing that on [redacted], she worked at the facility during the overnight shift from 12:00 midnight to 8:00 a.m. along with another staff member, who was also a Residential Trainer.

Under the [redacted] Policy and Procedure Manual IPOP, all staff persons were required to review the IPOP for every service recipient, at least on a quarterly basis or when there was a change or update. (Justice Center Exhibit 20) The record illustrates that the Service Recipient's IPOP was updated on [redacted] to include bed checks every 30 minutes while the Service Recipient slept. (Justice Center Exhibit 22) The Subject knew about the updated IPOP because she told Residential Trainer [redacted], who was working with the Subject that night, that the Service Recipient was to be checked every 30 minutes, and that the bed alarm did not work in his bedroom. (Justice Center Exhibits 7 and 34, Audio interrogation of [redacted]) Additionally, bed check protocols were boldly written and underlined on the top of the Service Recipient's Safety Checklist Form upon which the Subject signed her initials every 30 minutes from the start of her shift at 12:00 midnight until 6:30 a.m. the same morning of the incident. (Justice Center Exhibits 22, page 4 and 23; and Hearing testimony of Justice Center Investigator [redacted])

Yet, during her hearing testimony, the Subject admitted that she conducted bed checks for the Service Recipient at 2 hour intervals when he was asleep that night. This was clearly contrary to the Service Recipient's IPOP. The record illustrates that the Service Recipient was a known fall risk, had an extensive history of falling of which the subject was aware, and that his IPOP had been recently updated because his foot neuropathy had worsened. The neuropathy

ultimately caused him to fall more often. (Justice Center Exhibits 19, 20 and 21; and Hearing testimony of the Subject) The Subject testified that the Service Recipient fell almost daily and that she knew the Subject's foot neuropathy condition had worsened and that he had a habit of trying to stand or ambulate to the bathroom, without calling for staff assistance. Given this, it was imperative to the Service Recipient's safety that his bed checks be conducted every 30 minutes as mandated.

At the hearing, when asked what she did when she performed the Service Recipient's bed checks, the Subject testified that she used her "field of vision" whether she was working in the rear, or the front of the house. The Subject testified that she was stationed near the Service Recipient's bedroom from 2:00 a.m. until 4:00 a.m. on the relevant morning. The Subject testified that she was able to perform various tasks and conduct bed checks from her vantage point by looking into the Service Recipient's bedroom to see whether he was still sleeping in his bed. The Subject also testified that she was able to listen to the baby monitor to hear the Service Recipient breathe and that, while conducting the bed checks, there were times when she would stand at his bedroom door to look inside and check on him.

The Subject stated that when she performed tasks in the front of the house she checked on the Service Recipient more often and that at those times she would stand at the Service Recipient's bedroom doorway to look inside the room to make sure that he was still sleeping. At no time during her testimony did the Subject state that she actually entered the Service Recipient's bedroom, beyond his doorway, to actually observe that he was sleeping and not in any distress. Additionally, the Subject never ensured that the Service Recipient's safety equipment was properly functioning in his bedroom.

[redacted]

The Subject also testified that the bed alarm did not work when the Service Recipient got out of the bed and fell. Therefore, the Subject was not alerted by the bed alarm, which should have sounded through the baby monitor stationed in the Service Recipient's bedroom. Moreover, the hoyer lift normally used to lift the Service Recipient off of the floor was inoperable.

Nevertheless, the Subject had an absolute duty to conduct proper bed checks every 30 minutes, when the Service Recipient slept. This duty is not dependent on operational bed alarms or hoyer lifts. It should be noted that the Service Recipient's updated IPOP, dated [redacted], specifically mandated the use of "field of vision" supervision only when the Service Recipient was awake and in common areas such as the kitchen and living room and that staff was to assist the Service Recipient and remain "arm's length" when he stood or ambulated. (Justice Center Exhibit 22, page 3)

Given the Service Recipient's history of falling and his known propensity to get out of bed without calling for staff, the Subject should have conducted the mandated bed checks in a manner consistent with and at time intervals dictated by the IPOP. This may have prevented the Service Recipient's fall and, had the Subject actually made bed checks within the bedroom "every 30 minutes" as required, the Service Recipient may have been more susceptible to getting up to use the bathroom while the Subject was present in the room to assist him and prevent him from falling.

After considering all of the documentary evidence and testimony presented, it is concluded that the Justice Center has proved by a preponderance of the evidence that the Subject breached her custodial duties by failing to act in compliance with the Service Recipient's IPOP and that this omission resulted in, or was likely to result in, the Service Recipient sustaining

[redacted]

physical injury or serious or protracted impairment of his physical condition.

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

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category level of abuse or neglect set forth in the substantiated report**.**

Based upon the totality of the circumstances, the evidence presented and the witnesses statements, it is determined that the substantiated report is properly categorized as a Category 3 act.

A substantiated Category 3 finding of neglect will not result in the Subject being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL §496(2). This report will be sealed after five years.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized, as a Category 3 act.

[redacted]

This decision is recommended by Mary Jo Lattimore-Young,

Administrative Hearings Unit.

DATED: December 2, 2015
West Seneca, New York