

**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
AND ORDER
AFTER HEARING**

Adjud. Case #:

[REDACTED]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

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: February 16, 2018
Schenectady, New York



David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[REDACTED], Subject

**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:

John T. Nasci
Administrative Law Judge

Held at:

New York State Office Building
207 Genesee Street
Utica, New York 13501
On: [REDACTED]

Parties:

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

[REDACTED]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for 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], of neglect by the Subject of a Service Recipient.

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

Allegation 1

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while a custodian, you committed neglect when you failed to provide adequate medical care to a service recipient.

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 was retained.

4. The facility, the [REDACTED], located at [REDACTED], is a day habilitation facility for adults with mild to severe intellectual disabilities. The facility is operated by the [REDACTED] which is certified 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. (Hearing testimony of [REDACTED], [REDACTED] Corporate Compliance HIPAA Privacy Officer (Investigator))

5. At the time of the alleged neglect, the Subject had been employed by the [REDACTED] at the facility since [REDACTED] 2015, as a Licensed Practical Nurse (LPN). (Hearing testimony of the Subject) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was a seventy-one year old female who was a daily attendee at the facility. The Service Recipient had relevant diagnoses of Down syndrome, dementia, MR severe range, osteoporosis, and degenerative disk narrowing. (Justice Center Exhibits 24, 25 and 27) The Service Recipient had a history of complaining of hip and stomach pain. (Justice Center Exhibits 7, 10, 13, 16, 43, 46, 49 and 52; and Hearing testimony of the Subject)

7. On [REDACTED], sometime between 1:50 p.m. and 2:00 p.m., the Subject was in the facility walking from the nursing office directly across the hallway to Baseroom [REDACTED]. As she entered Baseroom [REDACTED], she passed by [REDACTED], Habilitation Specialist 1 (HS1) and the Service Recipient who were walking out of the Baseroom. Immediately after passing HS1 and the Service Recipient, the Subject turned around and saw the Service Recipient on the floor. (Justice Center Exhibits 2, 8, 9, 44 and 45; and Hearing testimony of the Subject)

8. The Subject asked HS1 what happened. HS1 responded that the Service Recipient had put herself on the floor. The Service Recipient then held her hands up to the Subject telling the Subject that she wanted to get up. The Subject then reached down, allowing the Service Recipient to grab the Subject's waist and pull herself up to a standing position. The Subject then asked the Service Recipient if she was OK. The Service Recipient responded saying that her hip hurt. The Subject told the Service Recipient to come into the nursing office so that she could have a look at her. The Service Recipient refused to go with the Subject and returned into Baseroom [REDACTED].

The Service Recipient displayed no apparent signs of having been injured. The Subject then told Staff A that she would check the Service Recipient later, after the Service Recipient's preferred facility employee [REDACTED], Habilitation Specialist 2 (HS2) returns from an outing and takes the Service Recipient to the bathroom. The Subject then returned to the nursing office and telephoned the Service Recipient's Individualized Residential Alternative (IRA) and informed an IRA employee of the incident. (Justice Center Exhibits 2, 8, 9, 10, 44, 45 and 46; and Hearing testimony of the Subject)

9. A short time later, HS2 returned to the facility from the outing, and the Subject walked with HS2 and the Service Recipient from Baseroom [REDACTED] to the bathroom. While the Service Recipient was toileting, the Subject performed a head-to-toe visual body check of the Service Recipient and noticed nothing out of the ordinary. After the Service Recipient was done in the bathroom, the Subject walked with HS2 and the Service Recipient back to Baseroom [REDACTED]. Neither HS2 nor the Subject observed any change in the Service Recipient's gait or any apparent sign of pain from the Service Recipient, or heard any complaints of pain from the Service Recipient. (Justice Center Exhibits 2, 8, 14 and 50; and Hearing testimony of the Subject)

10. Sometime between 3:00 p.m. and 3:30 p.m. the Service Recipient was transported by van from the facility back to the IRA. During the trip, the Service Recipient repeatedly complained of her hip hurting. Upon arriving at the IRA, the Service Recipient continued to complain about pain in her hip. After the IRA employees were unsuccessful in their attempts to have the Service Recipient lie in her bed, which resulted in more complaints of pain and screaming from the Service Recipient, an IRA employee telephoned 911 and had the Service Recipient transported by ambulance to [REDACTED] Hospital. (Justice Center Exhibits 6, 11, 12, 15, 18, 42, 47, 48, 51 and 55)

11. The Service Recipient was examined at [REDACTED] Hospital and diagnosed

with a subcapital impacted fracture of her left hip and was admitted. The Subject then underwent surgery, which consisted of “fixation of the fracture with percutaneous pins,” and remained in the hospital until [REDACTED]. (Justice Center Exhibit 28)

12. The [REDACTED] maintained a policy concerning staff’s responsibility in the event of a service recipient fall. The policy applied to [REDACTED] staff, including the Subject, who were trained in the policy during orientation upon hiring, medication certification, annual medical recertification and first aid training. The policy applied to service recipient falls whether the falls were witnessed or not witnessed. The policy provided, in pertinent part, that, after a fall by a service recipient, the service recipient was not to be moved before a head-to-toe check of the service recipient was performed, unless the service recipient was in immediate danger. The policy provided further that the service recipient was not to be moved until a complete head-to-toe check revealed no pain, no signs of injuries and no change in level of consciousness. (Justice Center Exhibit 39)

13. The Service Recipient was able to give or withhold consent for minor medical treatment. (Justice Center Exhibit 24 and 25; and Hearing testimony of the Subject)

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.

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 neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h), as follows:

"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 neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined as follows:

(c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject 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 whether

the act of neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as “Allegation 1” 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 through 33 and 38 through 55¹) The investigation underlying the substantiated report was conducted by the Investigator, who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and presented no other evidence.

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject’s action, inaction or lack of attention breached a duty that resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipients. (SSL §488(1)(h))

The Justice Center contends that the Subject had a duty to provide medical care to the Service Recipient upon learning that the Service Recipient had fallen, that the Subject breached this duty by failing to perform a full head-to-toe check of the Service Recipient in accordance with the [REDACTED] fall policy, and that the Subject’s breach of duty likely resulted in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

¹ The Justice Center did not offer Exhibits 34 through 37.

The Subject argues that the Service Recipient did not fall but instead put herself on the floor and, therefore, the [REDACTED] fall policy did not apply. The Subject argues that, nonetheless, she attempted to examine the Service Recipient immediately after the incident by asking the Service Recipient to go with her to the nursing office for an examination. The Subject argues that, the Service Recipient exercised her right to refuse the examination by not going to the nursing office, a right which she was afforded in her treatment plans.

There is no evidence in the record concerning whether a “fall” under the [REDACTED] policy includes or excludes a service recipient putting herself to the floor. However, such a distinction is not necessary in this instance. The Service Recipient was a seventy-one-year-old woman with multiple medical problems and physical ailments, not the least of which was osteoporosis. It can be reasonably concluded that a seventy-one year old service recipient with osteoporosis would likely suffer injury whether from an accidental fall or a purposeful fall. Indeed, the Subject admitted as much in her testimony by stating her opinion that the Service Recipient had the capability of putting herself to the floor and causing a fractured hip. (Hearing testimony of the Subject) Consequently, it is found that the Subject had a duty to follow [REDACTED] fall policy upon learning that the Service Recipient had just put herself on the floor.

The [REDACTED] fall policy required that the Subject refrain from moving the Service Recipient without first completing a head-to-toe check of the Service Recipient and ensuring that the Service Recipient suffered no pain, there were no signs of injuries and there was no change in level of consciousness of the Service Recipient. The policy allowed the Subject to move the Service Recipient only in the event the Service Recipient was in immediate danger. (Justice Center Exhibit 39) The evidence in the record establishes that the Subject did not complete a head-to-toe check of the Service Recipient before allowing the Service Recipient to move from where she had fallen. It was not until after the Service Recipient had regained her footing that the Subject suggested to

the Service Recipient to come to the nursing office for the Subject to examine her. The Subject's argument, that the Service Recipient refused to go to the office for examination, is without merit since the Subject's duty was triggered before the Service Recipient moved from where she had fallen. Consequently, the Subject breached her duty to perform a head-to-toe check of the Service Recipient before allowing the Service Recipient to move.

There is no evidence in the record that the Subject's breach of duty resulted in physical injury to the Service Recipient. However, the record reflects that the Subject's conduct was likely to have resulted in a several hour delay of the diagnosis and treatment of the Service Recipient's fractured hip, thereby causing protracted impairment of the Service Recipient's 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 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.

Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496 (2). The 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.

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

DATED: February 8, 2018
Schenectady, New York

A handwritten signature in dark ink, appearing to be 'J. Nasci', written over a horizontal line.

John T. Nasci, ALJ