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

ADJUDICATION CASE
[redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

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

[redacted]

By: John L. McMahon, Esq.
McMahon & Coseo, Attorneys
PO Box 587
16 Lake Avenue
Saratoga Springs, New York 12866

[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 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
December 11, 2014

David Molik
Administrative Hearings Unit

[redacted]

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

ADJUDICATION CASE [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: Justice Center for the Protection of People with Special Needs
401 State Street,
Schenectady, New York 12305
On: [redacted]

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
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[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (hereinafter "the VPCR") maintains a report substantiating [redacted] (hereinafter "the Subject") for abuse. 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.

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 [redacted] of neglect by the Subject of service recipient [redacted]

2. The initial report alleges, in pertinent part, that on or about [redacted] staff member [redacted] committed an act of neglect at the [redacted], by failing to pay adequate attention when dispensing medication to [redacted] resident [redacted] thereby allowing [redacted] to take more medication than prescribed. (Justice Center Exhibit 4)

3. The report was initially investigated by the Office of Children and Family Services, ("hereinafter the OCFS"). That investigation concluded that there was insufficient evidence of neglect and closed the matter based on a determination that the allegation was unfounded. However, the investigator for the Justice Center for the Protection of People with Special Needs ("hereinafter the Justice Center") upon review, reversed that finding and substantiated the allegation.

4. On or about [redacted], the Justice Center substantiated the report against the Subject for *neglect*. The Justice Center concluded that:

[redacted]

Offense 1

On [redacted], at the [redacted], located at [redacted], while acting as a custodian (YCW), you failed to properly supervise a service recipient during medication distribution, which allowed her to consume a larger dose of medication than indicated by her prescription.

This offense has been SUBSTANTIATED as a Category 3 offense pursuant to Social Services Law § 493.

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

6. At the time of the alleged neglect the Subject, [redacted], had been employed as a Youth Care Worker (hereinafter "YCW") on a per diem basis for approximately one month at the [redacted] (hereinafter [redacted]) located at [redacted]. The [redacted] operates under the OCFS, *a facility or provider agency* that is Subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 5)

7. At the time of the alleged neglect the service recipient, [redacted] had been a resident of the [redacted] for approximately four days (although she had resided at the [redacted] at least one time before that) and [redacted] had worked at the [redacted] on a few occasions during [redacted] periods of residence there. (Testimony of [redacted] Appellant)

8. On the evening/night shift of [redacted], [redacted] was the only staff on duty at the [redacted] to supervise four female residents who had been bickering, noncompliant and behaving badly throughout the evening. (Justice Center Exhibit 5)

9. At approximately 10:30 pm, it was approaching bedtime for the residents and [redacted] proceeded to dispense prescribed medication to them. Three of the residents were prescribed medication. (Testimony of [redacted]; Appellant)

10. At the time in question, the dispensing of medication was governed by The Policy and Procedure Manual-Medication Policy.[1] The procedure for dispensing medication was that the YCW enters the Youth Care Worker office and closes the half door leading to that room. The residents stand outside the room on the other side of the half door, one at a time. The YCW reviews the medication in the resident's binder, makes sure the resident has a cup of water and retrieves the resident's medication from the locked medication cabinet. A separate "baggie" is assigned to each resident and that "baggie" contains all of the medication prescribed for that resident. The YCW takes the bottle of medication out of the "baggie", one at a time and hands the medication to the resident. The resident takes out the prescribed amount of pills from that bottle, takes them immediately in the presence of the YCW and hands the bottle back to the YCW, who then returns the bottle to the "baggie". The same procedure is followed with each medication prescribed to that resident. Once a resident has finished, the YCW puts the "baggie" back into the cabinet and both she and the resident, initial the medication log. The same process is followed for each resident sequentially. (Justice Center Exhibit 8)

11. On , after dispensing medication to two of the other residents, dispensed to her three medications, including Clonidine. The dispensing of medication was unremarkable to at the time. (Testimony of Appellant)

12. Thereafter, the residents continued with their bed-time routine. was relieved by the next staff person and she ended her shift. (Testimony of ; Appellant)

13. The following morning on , , the Administrator, discharged from the because of aggressive behavior

[1] The Policy and Procedure Manual-Medication Policy (Justice Center Exhibit 8) was replaced by Policy and Procedure Manual—Updated Medication Policy as of (Justice Center Exhibit 16) shortly after this incident.

[redacted]

towards another resident throughout the previous weekend of [redacted]. [redacted] father picked her up. The Incident Resolution Form signed by [redacted] on [redacted] states that at that time;

> "... there was no indication that additional medications were taken and no information had been disclosed..." and that [redacted] "... displayed no ill affects of taking the medication..." (Justice Center Exhibit 14)

14. The next evening of [redacted] two [redacted] residents approached a staff member and disclosed to him that [redacted] had told them on the night of [redacted], that she had taken extra pills that night. (Justice Center Exhibit 14)

15. The on-call supervisor was notified of the information by the staff and he contacted [redacted] father to advise him of this disclosure. (Justice Center Exhibit 14)

16. At approximately 11:00 pm on [redacted], [redacted] father took [redacted] to [redacted] Emergency Department on the advice of [redacted] staff. (Justice Center Exhibit 5)

17. The hospital records indicate that the ER records indicated there was an overdose. The hospital staff ran numerous tests on [redacted] the results of which were inconclusive as to whether there had been an overdose. The decision was made to keep her overnight for observation, treating her case as a possible overdose. She received no medication and no treatment, other than hydration, during her short stay there. [redacted] was discharged the following day on [redacted] with the only instructions being to follow up with a mental health therapist. (Justice Center Exhibit 9)

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.

[redacted]

- Pursuant to Social Services Law § 493(4), the category level of abuse that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse 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 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."

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 a facility or provider agency 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.

[redacted]

(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

[redacted]

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;

[redacted]

(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.

[redacted]

(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 committed the abuse or neglect alleged in the substantiated report.

The issue in this case is whether [redacted] conduct constituted neglect under SSL § 488(1)(h) when she dispensed medication to [redacted] on [redacted].

In support of its indicated findings, the Justice Center presented a number of documents obtained during the investigation. (See Justice Center Exhibits 1-19) The Justice Center investigator testified for the Justice Center and the Subject testified on her own behalf at the hearing.

The OCFS Report contains notes of the interviews with [redacted] Administrator [redacted], [redacted] resident, [redacted], service recipient,

[redacted], service recipient's father, [redacted] staff, [redacted] and the Subject, [redacted] (Justice Center Exhibit 5)

The primary question of fact to be determined in this case is whether [redacted] paid adequate attention while dispensing [redacted] medication to her, thereby providing [redacted] with an opportunity to overdose. The Justice Center relied on evidence that [redacted] had looked or turned away from [redacted] while dispensing medication to her, together with evidence that [redacted] suffered from a medication overdose due to [redacted] failure to pay adequate attention to [redacted] while dispensing medication to her.

The OCFS investigator's notes indicate that [redacted] told him the following regarding [redacted] dispensing of her medication;

> "... I saw that she turned around to put the Risperidone back on the shelf and I poured a bunch of pills in my hand and ate them. When she turned around I handed her back the container. I don't know how many pills I took, I didn't look, I think maybe 5 or 6. The container still had a bunch of pills in it. Then I walked out of the staff office and went to bed. ..." (Justice Center Exhibit 5)

The [redacted] Incident Resolution Form (Justice Center Exhibit 14) indicates that two of [redacted] superiors were in contact with [redacted] several times on Monday night and Tuesday morning, [redacted] regarding the incident. It states that [redacted] contended that she only turned her back "for a second."

[redacted] was questioned numerous and repeated times over a short period of time by two different people and it is unclear to whom she made the admission, when it was made and in what context. In hearing testimony, [redacted] She vehemently denied having told [redacted] that she had turned around while dispensing [redacted] medication to her.

[redacted] hearing testimony was clear and forthright and, as such, her evidence was much more credible than the non-specific second hand account contained in the [redacted] Incident Resolution Form. [redacted] testified that she followed the existing medication dispensing

[redacted]

procedure set out in the [redacted] Policy and Procedure Manual—Medication Policy (Justice Center Exhibit 8) and dispensed [redacted] three medications without incident. [redacted] testified further that she watched [redacted] take her pills, that she did not turn her back on [redacted] that night and that she only glanced away to reach for the cup of water and to switch pill bottles when [redacted] did not have a pill bottle in her hand at the time. She further testified that she would have noticed if [redacted] had taken more than one pill. She remembered that [redacted] last pill was on a punch card and that [redacted] had asked her about the dosage. [redacted] checked the box for the correct dosage but, during that time, [redacted] did not have a pill bottle in her hand. After the medication was dispensed, both she and [redacted] initialed the Medication Log. (Justice Center Exhibit 10)

[redacted] testimony was consistent with the OCFS investigator's notes which indicate, that on [redacted], she had told him that she watched [redacted] take her medication that she may have looked down for a second, that she did not turn around and that she believed that [redacted] only took one pill. (Justice Center Exhibit 5)When cross-examined as to whether she was aware of [redacted] history of self-harm, the implication being that she should have been more vigilant, she quite correctly asserted that she was a per diem YCW who had been working very sporadically at the [redacted] for a short time and that she had been "thrown in" to supervise four troubled noncompliant teenagers by herself that night. There was no evidence that the [redacted] administration had taken any steps to alert [redacted] of [redacted] history of self-harm.

It is noteworthy that the limitations upon the dispensing of medication at the [redacted] prevent [redacted] staff from opening medication bottles or handling pills. Furthermore, at the time of the incident, there was no provision for confirming the number of pills being taken or for the inventorying of residents' medication at all.

[redacted]

Since the time of this incident, The [redacted] Policy and Procedure Manual-Medication Policy has been revised. (Justice Center Exhibit 16) Now monitoring the inventory of each resident's medication has been instituted. Also, and more importantly in this case, the residents must now show the staff, who is dispensing medications, their open hand of pills before ingesting them. These safeguards were not in place when [redacted] dispensed [redacted] medication.

The Justice Center had also attempted to establish that [redacted] did actually suffer from an overdose of medication in furtherance of its theory that [redacted] did not pay adequate attention when she dispensed medication to [redacted].In reliance on a finding that [redacted] overdosed on her medication, the Justice Center's evidence were the statements made by [redacted] to the OCFS investigator, a [redacted] log book recording the disclosure of the two other residents to staff and [redacted] statements to her [redacted] staff supervisor and the OCFS investigator.

The OCFS investigator's notes indicate that [redacted] told him regarding [redacted] dispensing of her medication that;

> "... I saw that she turned around to put the Risperidone back on the shelf and I poured a bunch of pills in my hand and ate them. When she turned around I handed her back the container. I don't know how many pills I took, I didn't look, think maybe **5 or 6**. The container still had a bunch of pills in it. Then I walked out of the staff office and went to bed. I felt OK. I didn't get sick. I woke up the next day and felt a little tired but wasn't sick. I told [redacted] and [redacted] the next morning that I was tired because I took a bunch of pills ... My Dad made me go to the hospital. I was fine. They checked me out and said I could go home ... They told me that I didn't have any symptoms and that I could go home ..." (Emphasis added) (Justice Center Exhibit 5)

At the time that the allegation was substantiated by the Justice Center investigator, the [redacted] records had not yet been made available to the investigator, but at the Hearing, the medical records were introduced into evidence to support the finding of an overdose.

[redacted]

The medical records indicate that [redacted] told hospital staff that she swallowed **10-15** pills. (Emphasis added) (Justice Center Exhibit 9) However, the OCFS investigator's notes indicate that [redacted] father told him that when he questioned his daughter about whether she took more pills than prescribed on [redacted], she denied it completely. (Justice Center Exhibit 5)

The entry dated [redacted] of the [redacted] Communications Log Book, author unknown, states that;

> "... [redacted] and [redacted] told me tonight that apparently, past resident [redacted] last night was extremely upset and took a bunch of her sleeping pills, instead of her regular dosage ..." (Justice Center Exhibit 12)

The OCFS investigator's notes indicate that, on [redacted], [redacted] told him that;

> "... I don't know if she took any meds on the night before she got discharged. I went to sleep and then when I woke up I talked to [redacted] She was o.k. She wasn't sick ..." (Justice Center Exhibit 5)

While there was some evidence admitted that [redacted] was behaving strangely or was having symptoms that might have been consistent with a drug overdose, such as feeling tired, dizzy, short of breath, chest pains and stumbling, these symptoms were nonspecific in nature. Each account was different from the other, and there is no way of verifying that any of these things related to the ingestion of medication. In any case, all of the evidence emanating from [redacted] herself is so inconsistent as to be totally unreliable.

Furthermore, the interval of time that elapsed between when [redacted] took her medication at the [redacted] and when she was seen at the hospital was approximately twenty-four hours. She could have been exposed to anything after being discharged from the [redacted] that may have accounted for whatever symptoms [redacted] claimed to have experienced.

[redacted]

Based on these significant discrepancies in the evidence, it was not established that, in fact, an overdose occurred as alleged. Although this conclusion would, in and of itself be determinative of the issues herein, the question of whether [redacted] conduct amounted to neglect is the more fundamental issue.

[redacted] hearing testimony was much more credible than [redacted] accounts of the incident.

Upon examination of the evidence, it was not established that [redacted] turned her back while dispensing medication to [redacted] or even that an overdose occurred. [redacted] executed her duties properly and followed the medication dispensing procedure as set out in the [redacted] Policy and Procedure Manual that existed at that time.

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

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

[redacted]

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

DATED: December 11, 2014
Schenectady, New York