**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

Administrative Appeals Unit
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]

By: Jason Jaros, Esq.
Jaros & Jaros
8207 Main Street, Suite 13
Williamsville, New York 14221

[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 pertaining to Allegation 1 is properly categorized as a Category 2 act.

The substantiated report pertaining to Allegation 2 is properly categorized as a Category 3 act.

The substantiated report pertaining to Allegation 3 is properly categorized as a Category 2 act.

The substantiated report pertaining to Allegation 4 is properly categorized as a Category 2 act.

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of these reports shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years

[redacted]

pursuant to SSL §§ 493(4)(b) and 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**: April 6, 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: Gerard D. Serlin
Administrative Law Judge

Held at: Administrative Hearing Unit
New York State Justice Center for the Protection of People with Special Needs
200 East & West Road
West Seneca, New York 14228
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

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]

By: Jason Jaros, Esq.
Jaros & Jaros
8207 Main Street, Suite 13
Williamsville, New York 14221

## 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], [redacted] of neglect by the Subject of a Service Recipient.

2. After investigation of [redacted] role in the report, the Justice Center concluded that:

### Allegation 1

It was alleged that on various dates between [redacted] and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to properly document the status updates for a service recipient's pressure wounds, failed to properly administer his medication, and/or failed to accurately document administration of his medication.

These allegations have been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4) (b).

### Allegation 2

It was alleged that between [redacted] and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to ensure that a service recipient received a treatment and dietary supplement in a timely fashion.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4) (c)

**Allegation 3**

It was alleged that between [redacted] and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you instructed staff to treat a service recipient's wounds differently than as prescribed by his physician, without seeking approval.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law§ 493(4) (b).

**Allegation 4**

It was alleged that between [redacted] and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to ensure staff was completing documentation on the treatment of a service recipient's wounds.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law§ 493(4) (b).

3. An Administrative Review was conducted and as a result, the substantiated report was retained. The facility, [redacted], is a group home located at [redacted], and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center.

4. At the time of the alleged neglect, the Subject had been employed in the capacity of Direct Assistant-2 (DA-2) for approximately one year and was the facility "house supervisor." The Subject had been employed by the provider agency for approximately ten years. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

5. At the time of the alleged neglect, the Service Recipient had been a resident of the facility for approximately two years. (Justice Center Exhibit 32, p. 2) The Service Recipient

was a person who used a wheelchair, but could go from a seated to a standing position for transfers. (Hearing testimony of Subject) The Service Recipient was also a person with an unspecified psychiatric disorder, diabetes and significant neuropathy. (Hearing testimony of OPWDD RN [redacted]; Justice Center Exhibit 5) Because the Service Recipient was diabetic and nearly always required a wheelchair, he historically suffered from pressure wounds on his buttocks. (Hearing testimony of OPWDD RN [redacted]; Justice Center Exhibit 5)

6. The Service Recipient attended a day program Monday through Friday. (Hearing testimony of OPWDD Investigator [redacted]) On [redacted], staff at the day program discovered and documented two pressure wounds on the Service Recipient's buttocks. (Hearing testimony of OPWDD RN [redacted])

7. The Service Recipient had a medical appointment on [redacted], in which a medical practitioner evaluated the pressure wounds and noted the wounds to be two "pea sized" wounds 1 cm by .5 cm on the buttocks, with no evidence of infection. The medical practitioner prescribed Allevyn adhesive dressing (the dressing), 3 inch by 3 inch size to be applied once daily. (Justice Center Exhibits 5, 9 and 10a) The purpose of the dressing was not only to protect the wound from debris and foreign organisms but also to promote healing by maintaining a specified temperature range and keeping the wound moist. (Hearing testimony of OPWDD RN [redacted])

8. The Registered Nurse (RN) initially responsible for the care of the Service Recipient (Nurse-A) created a pressure wound Plan of Nursing Services (PONS) on [redacted]. The Subject and other direct care staff members signed and acknowledged the PONS. (Justice Center Exhibit 17) The PONS required that facility direct care staff document the

wound condition in the Service Recipient's [redacted] residential notes after each daily dressing change. Specifically, the PONS stated, in relevant part, that staff was instructed to note in the residential notes the "… appearance of wound bed, presence of odor, color, amount of drainage and surrounding tissue appearance after each daily dressing change …" (Justice Center Exhibit 17) The PONS also stated, in bold letters, "all staff at time of initial training must read and sign the back of this (PONS) form." (Justice Center Exhibit 17) All of the staff at the facility signed the "PONS Q&A Signature Sheet." (Justice Center Exhibit 17) While the Subject did sign the PONS, she did not read the PONS during the relevant time. (Hearing testimony of the Subject)

9. The provider agency practice and protocol is that a service recipient's Medication Administration Record (MAR) dictates when, and what type of medication or treatment, that a service recipient receives from direct care staff members. Furthermore, each time the wound was treated, documentation of the treatment was required to be made by the direct care staff member in the MAR. (Hearing testimony of OPWDD Investigator [redacted]; Hearing testimony of Subject).

10. Following the medical appointment of [redacted], a direct care staff member correctly transcribed the prescription for the dressing into the Service Recipient's MAR. (Justice Center Exhibit 21)

11. The Service Recipient's MAR indicates that, between [redacted], the Service Recipient's dressing was changed daily. However, none of the direct care staff members under the supervision of the Subject complied with the directive in the PONS to document the "… appearance of wound bed, presence of odor, color, amount of drainage and

surrounding tissue appearance after each daily dressing change …" in the residential notes. (Justice Center Exhibits 17, 20 and 21)

12. By email dated [redacted], the agency dietician recommended that the supplement Arginaid (the supplement) be given to the Service Recipient to enhance his capacity for wound healing. The email was sent to Nurse-A, and to the house supervisor. (Justice Center Exhibit 24)

13. On [redacted], the Service Recipient's pressure wounds were evaluated by a medical practitioner. During the evaluation, the medical practitioner began to suspect infection and therefore prescribed an antibiotic. The medical practitioner also obtained a wound tissue sample to culture in order to identify the bacteria and, thereafter, recommended an antibiotic that would be effective against said bacteria. (Hearing testimony of OPWDD [redacted]; Justice Center Exhibits 6 and 9) The medical practitioner took no measurements of the pressure wounds and characterized the wounds as Stage 1[1] (right buttock) and Stage 2 (left buttock). The medical practitioner directed continuing the use of the dressing once daily for both wounds, but also prescribed Duoderm Hydroactive Sterile Gel (the gel), to be applied once daily, to the wound on the left buttock. (Justice Center Exhibit 6)

14. After the medical appointment of [redacted], a direct care staff member transcribed the prescription for the gel into the Service Recipient's MAR, but did not include the additional critical directive provided by the medical practitioner to administer the gel, along with the dressing, to the wound on the left buttock. (Justice Center Exhibit 21) Another direct care

[1] Pressure wounds are commonly staged as follows: an area of the skin reddens in Stage 1, after which a wound penetrates the first and second layers of skin in Stages 2 and 3, respectively, until the wound reaches the muscle and bone in Stage 4. (Hearing testimony of OPWDD RN [redacted])

staff member, who had the job of verifying the directions in the MAR, did not notice the error. (Hearing testimony of OPWDD RN [redacted])

15. Sometime after [redacted], the Subject directed facility staff, including staff member-A and staff member-B, to remove the dressing from the Service Recipient's wounds in the evening and to keep the wounds uncovered overnight. (Hearing testimony of the Subject and Justice Center Exhibits 3, 27 and 32, pp 19 through 21) The Subject may have consulted with the Nurse-A before advancing this directive. (Hearing testimony of the Subject; Justice Center Exhibit 3-Note #33, twenty seventh page; Justice Center Exhibit 32)

16. The Service Recipient's wounds were left uncovered during the overnights on [redacted]. (Justice Center Exhibit 3, Note #20, #25, #28, and #38; Justice Center Exhibit 20; Justice Center Exhibit 35; Hearing testimony of Subject; Hearing testimony of OPWDD RN [redacted])

17. On [redacted], there was a clinical meeting attended by the Subject concerning the Service Recipient at which time the supplement was discussed. (Justice Center Exhibit 26) Before this meeting, the Subject did not read the email of [redacted]. After the meeting of [redacted], the Subject read the email and called the medical practitioner's office to inform staff that the request for the supplement was coming. The Subject then faxed the request to the Service Recipient's medical practitioner. (Hearing testimony of the Subject)

18. The Service Recipient was evaluated again by an outside medical practitioner on [redacted]. The medical practitioner described the Service Recipient's pressure wound on the left buttock as a Stage 2 pressure ulcer and made no mention of a wound on the right buttock. (Justice Center Exhibit 8; Hearing testimony of OPWDD RN [redacted])

19. The Subject did not thereafter follow up with the facility staff member who had accompanied the Service Recipient to the [redacted] medical appointment, to ensure that a prescription for the supplement was obtained, or to determine if the medical practitioner would prescribe the supplement. (Hearing testimony of the Subject) Ultimately, the medical practitioner did prescribe the supplement, but not until after an additional week had elapsed. The supplement arrived at the facility on [redacted]. (Justice Center Exhibit 21 and 25)

20. On [redacted], the Subject changed the Service Recipient's dressing. (Justice Center Exhibit 21) However, the Subject failed to document the condition of the wounds in the residential notes as directed by the PONS. (Justice Center Exhibits 20 and 21; Hearing testimony of the Subject)

21. On [redacted], the Subject applied the dressing to the Service Recipient during the morning hygiene task but failed to document that she had done so in the MAR. Instead, the Subject allowed staff member-C to incorrectly document in the MAR that he had been the one who had applied the dressing. (Justice Center Exhibit 21) On that same date, the Subject also failed to document the condition of the wounds in the residential notes, as directed by the PONS. (Justice Center Exhibit 20)

22. On [redacted], after the Subject changed the dressing, she failed to document the dressing change in the MAR, as required by provider agency protocol and the PONS. The Subject also allowed staff member-D to erroneously document in the MAR that she had changed the dressing when, in fact, the Subject had changed the dressing. (Justice Center Exhibit 3, p. 24; Justice Center Exhibit 21)

23. The Service Recipient was next evaluated by an outside medical practitioner on [redacted], when he was seen by a wound care practitioner. OPWDD [redacted]

[redacted] accompanied the Service Recipient to the medical appointment. The medical practitioner continued the most recent antibiotic prescription as written by the medical practitioner two days earlier, and additionally prescribed a chemical debridement agent, a medication intended to dissolve necrotic tissue in the wound. The wound could not be staged when viewed by the wound care practitioner because damaged tissue prevented good visualization of the wound. (Hearing testimony of OPWDD RN [redacted])

24. From [redacted] until [redacted], the Service Recipient was not seen by a medical practitioner other than RN [redacted], but phone consultations transpired between RN [redacted] and the wound care practitioner on a regular basis. The Service Recipient continued to display signs of active infection. (Hearing testimony of OPWDD RN [redacted])

25. On [redacted], the Service Recipient experienced a decline in his level of consciousness and was admitted to the hospital where he was diagnosed as septic, meaning that a bacterial infection was running throughout his body and was not localized. The Service Recipient underwent surgical debridement of the left buttock wound and was treated with a course of intravenous antibiotics, which lasted approximately two weeks. He remained hospitalized during this time. (Hearing testimony of OPWDD RN [redacted]) The Service Recipient's left buttock wound bed could then be seen and his wound condition was classified as Stage 4, which meant that the wound opening penetrated into his muscle, tendons and bones. (Hearing testimony of OPWDD RN [redacted])

26. The Service Recipient then returned to the facility in late [redacted], and was prescribed oral antibiotics. (Hearing testimony of OPWDD RN [redacted] In [redacted], [2] the Service Recipient was again admitted to the hospital and was again treated with intravenous

[2] The date was not definitively established in the record.

antibiotics. An MRI of the Service Recipient revealed a bacterial infection of the bone underlying the debrided wound bed. While in the hospital, a peripherally inserted catheter (PIC) was inserted into the Service Recipient for post-hospital administration of intravenous antibiotics used in the treatment of bacterial infection of the bone. (Hearing testimony of OPWDD RN [redacted]) On or about [redacted],[3] the Service Recipient was released to a rehabilitation program for administration of the antibiotics specifically for the treatment of the bacterial bone infection. (Hearing testimony of OPWDD RN [redacted])

27. However, the Service Recipient's wound condition continued to worsen. Thereafter, on [redacted], the Service Recipient became unresponsive and was hospitalized, as he was suffering from septic shock. (Hearing testimony of OPWDD RN [redacted]) The Service Recipient died on [redacted]. (Justice Center Exhibit 29)

28. The Service Recipient's death was, in part, attributable to his pressure wounds and the resulting septicemia. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibit 29)

## 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.

[3] The date was not definitively established in the record.

## APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3) (c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1). Neglect under SSL § 488 (1) (h) is defined as:

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

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Categories 2 and 3, which are defined as follows:

> (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.

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 the acts described in Allegations 1, 2, 3 and 4 of the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-32[4] and 35) The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted]. OPWDD RN [redacted] also testified at the hearing on behalf of the Justice Center.

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

[4] Including Justice Center Exhibit 10 a.

**Allegation 1**

The Justice Center proved by a preponderance of the evidence that on [redacted] the Subject changed the Service Recipient's dressing. (Justice Center Exhibits 21 and 3, p. 24) However, the Subject failed to document the condition of the Service Recipient's wounds in the residential notes as directed by the PONS, on any date when she changed the dressing. (Justice Center Exhibits 20 and 21; Hearing testimony of the Subject)

The Justice Center further proved by a preponderance of the evidence that on [redacted], after the Subject changed the dressing, she failed to document the dressing change in the MAR, as required by provider agency protocol and the PONS. The Subject also allowed staff member-D to erroneously document in the MAR that she had changed the dressing when, in fact, the Subject had changed the dressing. (Justice Center Exhibit 3, p. 24; Justice Center Exhibit 21)

The Justice Center has established by a preponderance of the evidence that the Subject failed to properly document the status updates for the Service Recipient's pressure wounds, and failed to accurately document administration of his medication. Specifically, the Subject failed to document the condition of the wounds in the residential notes after each dressing change, and failed to accurately document administration of the Service Recipient's medication when she allowed a facility direct care staff member under her supervision to document in the Service Recipient's MAR that the direct care staff member had changed the dressing, when the Subject had actually changed the dressing.

With regard to Allegation 1, there was no evidence that the Subject's failure to document the condition of the wounds in the residential notes or the dressing changes in the MAR actually resulted in physical injury, or serious or protracted impairment of the physical, mental or

emotional condition of the Service Recipient. However, such evidence is not necessary for a finding of neglect. The fact that the Subject allowed staff who did not change the Service Recipient's dressing to falsely document in the MAR that they had done so, created an environment where it was acceptable to both fail to administer treatment and falsely document that treatment was administered, and such an environment was likely to result in the serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

The Justice Center proved by a preponderance of the evidence not only that the Subject's inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. 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 in Allegation 1. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated allegation**.** Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of the Subject, the Subject's neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated allegation is properly categorized as a Category 2 act.

A substantiated Category 2 finding of abuse or neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not

elevated to a Category 1 finding shall be sealed after five years.

**Allegation 2**

The Subject testified that she did not have home access to her work email and that the only way she could access the email was during work hours at the facility. The Subject testified that she first became aware of the recommendation for the supplement at the [redacted] clinical meeting. After the meeting, the Subject looked for the email from the dietician of [redacted], but was unable to locate it. The Subject then asked the dietician to resend the email of [redacted]. The Subject testified that she received many emails, but that she usually only read "flagged items." The Subject testified that she did not "see" the e-mail regarding the supplement when it was first sent.

The Subject testified that upon receiving a directive to obtain a prescription, she was responsible for sending the request by facsimile to the medical practitioner. In this particular case, the Subject testified that, for reasons unknown to her, the medical practitioner did not immediately respond to her request and that it took approximately one week for the medical practitioner to approve and submit a prescription for the supplement to the appropriate pharmacy.

It is clear from the Subject's hearing testimony that she did not read the email pertaining to the supplement sent by the dietician on [redacted]. It is also evident that, after becoming aware of the issue on [redacted], the Subject took no additional action with the medical practitioner beyond her initial call to his office and her initial facsimile request.

The Justice Center proved by a preponderance of the evidence that the Subject had a duty to obtain the dietary treatment/supplement and that she failed to ensure that the Service Recipient received the dietary treatment/supplement in a timely fashion. The dietary treatment/supplement had potential to aid in the healing of wounds. (Justice Center Exhibit 24)

The Justice Center proved by a preponderance of the evidence not only that the Subject's inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. 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.

The report will remain substantiated and the next question to be decided is whether the substantiated allegation constitutes the category of abuse 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 allegation is properly categorized as a Category 3 act.

A substantiated Category 3 finding of 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 NY SSL § 496 (2). This report will be sealed after five years.

**Allegation 3**

The Justice Center proved by a preponderance of the evidence that sometime after [redacted], the Subject directed facility staff members A and B to remove the dressing from the Service Recipient's wounds in the evening and leave the wounds uncovered overnight. As a result, the Service Recipient's wounds were left uncovered during the overnights on [redacted].

The Subject testified that she conferred with Nurse-A, and, ultimately followed the lead of Nurse-A in advancing the directive to remove the dressing from the Service Recipient during the overnights. The Subject also took this position during interrogation at the time of investigation. While the Subject may have had some conversation with the Nurse-A about leaving the wound uncovered, (Justice Center Exhibit 3, Note #33, p. 27; Justice Center Exhibits 3 and 32), the Subject's testimony and interrogation statement on this issue are not credited evidence. Irrespective, the Subject acted without the authority of an authorized medical practitioner such as a Physician, Physician Assistant or Nurse Practitioner when she directed staff to alter the Service Recipient's treatment.

The Justice Center has established by a preponderance of the evidence that the Subject instructed staff to treat a Service Recipient's wounds differently than as dictated by his medical practitioner, without seeking prior approval.

The Subject's role in causing the wound to be left uncovered during the overnight was a factor in the deterioration of the left buttock wound. The evidence established that during the fifteen-day period, between [redacted] and [redacted], the Service Recipient's left buttock wound deteriorated rapidly, and by [redacted] the left buttock wound was filled with necrotic tissue and could not be staged because visualization of the wound bed was not possible.

The left buttock wound continued to deteriorate and the Service Recipient experienced sepsis for the first time in [redacted]. On [redacted], the necrotic tissue in the wound on the left buttock was surgically debrided. An infection of the bone ensued in [redacted], which was believed to have started at the site of the surgical debridement. Ultimately, even after a six-week course of intravenous antibiotics, the Service Recipient experienced septic shock again and died in [redacted]. The Service Recipient's pressure wounds were determined to be a

contributing factor in his death. (Hearing testimony of OPWDD RN [redacted] and Justice Center Exhibit 29)

The Justice Center proved by a preponderance of the evidence not only that the Subject's inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely, and actual, result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. 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 in Allegation 3. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated allegation constitutes the category of neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of the Subject, the Subject's neglect seriously endangered the health, safety or welfare of the Service Recipient. Therefore, it is determined that the substantiated allegation is properly categorized as a Category 2 act.

A substantiated Category 2 finding of neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

**Allegation 4**

The Subject, in her capacity as the house manager, was responsible for ensuring that her staff followed the documentation directives in the PONS. The PONS required that facility direct

care staff document the wound condition in the Service Recipient's [redacted] residential notes after each daily dressing change. Between [redacted], none of the staff members under the supervision of the Subject correctly documented in the residential notes the condition of the Service Recipient's wounds, as specifically required by the PONS.

While there was no evidence that the Subject's failure to ensure that staff whom she supervised documented the condition of the wounds in residential notes actually resulted in physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, such evidence is not necessary for a finding of neglect. Considering this Service Recipient's medical conditions and history of pressure wounds, appropriately documenting the condition of his wounds was a significant factor in his potential recovery.

The Justice Center proved by a preponderance of the evidence not only that the Subject's inaction and/or lack of attention breached her duty to the Service Recipient, but also that the likely result of such breach was physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that Subject committed the neglect alleged in Allegation 4. The substantiated report will not be amended or sealed.

The report will remain substantiated and the next issue to be determined is whether the substantiated allegation constitutes the category of neglect set forth in the substantiated report**.** This Service Recipient's medical conditions and history of pressure wounds rendered him at significant risk for medical complications and poor pressure wound healing. The PONS required the documentation to be made in the residential notes so that provider agency nursing staff could

make assessments about the status of the wounds' condition. The absence of that documentation had the potential to negatively affect decisions made by provider agency nurses pertaining to the Service Recipient's care. More specifically, the failure to appropriately document signs of infection and the condition of the wounds seriously endangered the health, safety or welfare of the Service Recipient. Based upon the totality of the circumstances, the evidence presented, the witnesses' statements, and considering the omissions and the commissions of the Subject, it is determined that the substantiated allegation is properly categorized as a Category 2 act.

A substantiated Category 2 finding of neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

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 in Allegations 1, 2, 3 and 4. The substantiated report will not be amended or sealed.

**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 pertaining to Allegation 1 is properly categorized as a Category 2 act.

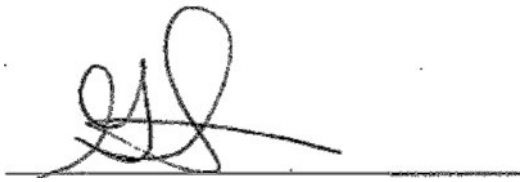
The substantiated report pertaining to Allegation 2 is properly categorized as a Category 3 act.

The substantiated report pertaining to Allegation 3 is properly categorized as a Category 2 act.

The substantiated report pertaining to Allegation 4 is properly categorized as a Category 2 act.

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

**DATED**: March 10, 2016
Syracuse, New York



Gerard D. Serlin, ALJ