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]

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: William T. Burke, Esq.
O'Neil & Burke, LLP
135 North Water Street
Poughkeepsie, New York 12601

[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] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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: May 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: Jean T. Carney
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
4 Burnett Boulevard
Poughkeepsie, New York, 12601
On: [redacted]

Parties: Vulnerable Persons' Central Register
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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 acting as a custodian, you committed neglect when you provided inadequate medical care for a service recipient by failing to obtain her prescription medication after she was discharged from the emergency room.
>
> 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, located at [redacted], is an [redacted] operated by the [redacted], and is certified by the Office for People With Developmental Disabilities (OPWDD) which is a facility or provider

agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject had been employed by the [redacted] for 12 years. The Subject worked as a Direct Support Assistant (DSA).

6. At the time of the alleged neglect, the Service Recipient was 45 years of age, and had been a resident of the facility for an unknown period of time. The Service Recipient is an adult female with a diagnosis of mild mental retardation. (Justice Center Exhibit 12)

7. On [redacted], as the Service Recipient was being transported back to the [redacted], her seatbelt became loose and she fell to the floor. The driver, DA1 [redacted], continued to the residence and reported the incident. DA1 [redacted] was instructed to bring the Service Recipient to the hospital for an evaluation. (Justice Center Exhibit 5)

8. At the hospital, the Service Recipient was diagnosed with a fracture to her metacarpal bone. Her hand was placed in a splint, and she was given two prescriptions for pain. DA1 [redacted] returned to the [redacted] with the Service Recipient, and handed the discharge instructions along with the prescriptions to DA1 [redacted]. At that point, DA1 [redacted] shift had ended, so she left the [redacted]. (Hearing testimony of OPWDD Investigator [redacted][1], Justice Center Exhibits 5, and 15)

9. DA1 [redacted] called the Nurse Administrator On Duty (NAOD), RN [redacted], who completed the [redacted] Telephone Triage Consultation Form and faxed the form to DA1 [redacted]. The form instructs staff, among other things, to start new medications as ordered. DA1 [redacted] signed the form, acknowledged that she understood the instructions, and faxed the form back to the NAOD. (Hearing testimony of Investigator [redacted], Justice Center Exhibits 5, 18, and 28)

[1] At the time of the incident, [redacted] worked for OPWDD and investigated the incident in that capacity. At the time of the hearing, [redacted] was working for the Justice Center as an investigator.

10. DA1 [redacted] was AMAP certified, meaning that she was authorized to administer medications to the service recipients residing in the [redacted]. The Subject was not AMAP certified, and had not handled medication for more than a year. During her shift on [redacted], the Subject was responsible for preparing meals, cleaning, and doing laundry. The Subject was not assigned to medication duty. (Hearing testimony of Investigator [redacted], Justice Center Exhibits 7, and 28)

11. DA1 [redacted] was the senior staff for that shift and was in charge for that shift. She never discussed the NAOD's instructions for treating the Service Recipient with the Subject. DA1 [redacted] did not tell the Subject that the Service Recipient was given prescriptions for pain medication. DA1 [redacted] did not get the prescriptions filled, nor did she ask the Subject to do so. (Hearing testimony of Investigator [redacted], Justice Center Exhibit 28, and Hearing testimony of 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 abuse and neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been

made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3[f])

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1), to include:

> (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.

Substantiated reports of abuse and/or 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 failed to establish by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report.

In support of its findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-27) In addition, the Justice Center presented an audio CD of the interrogation of both the Subject and DA1 [redacted]. (Justice Center Exhibit 28) The investigation underlying the substantiated report was conducted by OPWDD Investigator [redacted], who was the only witness who testified at the hearing on behalf of the Justice Center.

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

In order to prove neglect, the Justice Center must show that the Subject breached her duty to the Service Recipient by either an action, or a failure to act, or lack of attention. In this case, the Justice Center posited that the Subject's failure to fill the Service Recipient's prescriptions constituted a breach of duty. However, the evidence introduced at the hearing showed that the Subject had no idea that the Service Recipient had been prescribed medication. When DA1 [redacted] brought the Service Recipient back to the [redacted] from the hospital, she transferred supervision of the Service Recipient to DA1 [redacted]. DA1 [redacted] had no contact with the

Subject. DA1 [redacted] handled all contact with the NAOD regarding the Service Recipient's care. There was no evidence to suggest that the Subject had any knowledge whatsoever regarding the Service Recipient's injury and treatment. (Justice Center Exhibits 5, 14, 18, 19, and 28) The Subject cannot be found to have breached her duty to act (filling the Service Recipient's prescription at the pharmacy) because she was unaware that such action was required, and would have had no reason to know that such action was required.

In the alternative, the Justice Center argued that the Subject breached her duty by being inattentive to the Service Recipient's needs. However, there was no evidence to support this argument. The unrefuted evidence introduced at the hearing establishes that the Subject was not authorized to dispense medication, and therefore was prohibited from giving any medicine to the Service Recipient.

The Justice Center pointed out that the Subject could have picked up medication from the pharmacy, and was trained in how to utilize the after-hours procedure for getting prescriptions re-filled. (Hearing testimony of Investigator [redacted], Justice Center Exhibits 9, and 25) This argument is unpersuasive due to the Subject's lack of knowledge of the need to fill the prescriptions. In addition, the training referred to by the Justice Center concerns the procedure for re-filling or re-ordering existing maintenance medications, not getting new prescriptions filled. (Justice Center Exhibit 25) In order to get a prescription re-filled, staff need only call the pharmacy and go pick up the medication when it is ready. However the procedure is different when new medication is prescribed. Furthermore, the excerpt from the facility log book also outlines the procedure for calling the pharmacy; but it states at the top of the page "To all AMAPS" and as the Subject is not AMAP certified, there was no reason for her to have read that document. (Justice Center Exhibit 9) Therefore, the Justice Center failed to show that the

Subject breached her duty to the Service Recipient.

The Justice Center failed to establish that the Subject owed a duty to ensure that that the Service Recipient's medication was administered. In addition, the Justice Center failed to establish that the Subject breached her duty of care by not ensuring that the Service Recipient's prescriptions were filled. The Subject cannot be held accountable for failing to perform a duty she was not privy to.

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. The substantiated report will be amended or sealed.

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

This decision is recommended by Jean T. Carney, Administrative Hearings Unit.

DATED: April 29, 2016
Schenectady, New York

Jean T. Carney
Administrative Law Judge