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]

[redacted]

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

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

The substantiated report is properly categorized, as Category 2 acts.

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 pursuant to SSL § 493(4)(b).

[redacted]

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: November 8, 2016
Schenectady, New York

David Molik
Administrative Hearings Unit

STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
Administrative Hearings Unit
1200 East and West Road
West Seneca, New York 14224
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
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[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], [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 failed to ensure and document that a service recipient's oxygen was properly connected, which resulted in the service recipient going without required oxygen for several hours.

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

Allegation 2

It was alleged that on [redacted] at the [redacted], located at [redacted] while acting as a custodian, you committed neglect when you "capped" off the connector to a service recipient's oxygen without seeking clarification as to whether that was correct.

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.

4. The facility, located at [redacted] is an [redacted] for developmentally disabled persons requiring twenty-four hour nursing and staffing care. The facility is operated by [redacted], a private not-for-profit agency certified by the New York State Office for People With Developmental Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. At the time of the incident, there were twelve service recipients residing at the [redacted] facility. (Hearing testimony of [redacted] Quality Improvement (QI) Specialist)

5. At the time of the alleged neglect, the Subject was employed by [redacted] as a Direct Support Professional (DSP). The Subject's duties included providing hands-on care of service recipients including assisting them with their daily living activities (ADLs), and performing bed/oxygen checks. The Subject had worked at the facility for approximately one year prior to the incident. The Subject typically worked the 10:30 p.m. to 8:30 a.m. overnight shift. The Subject was a custodian as that term is so defined in SSL § 488(2).

6. The Subject was certified to distribute and administer medications to residents and she documented these activities in the Medical Administration Record (MAR). Additionally, the Subject successfully completed oxygen and tracheostomy competency training in May of 2013. The Subject had previously worked with service recipients who received oxygen and although trained to do so, she had not actually performed tracheostomy care as a DSP. (Hearing testimony of the Subject; Justice Center Exhibit 6, item 5 at page 15; and Justice Center Exhibits 13, 16-17)

7. At the time of the alleged neglect, the Service Recipient was an adult male approximately nineteen years old and had been a facility resident since [redacted] The

Service Recipient was non-verbal and communicated through facial expressions and body movements, such as nodding yes or no. The Service Recipient ambulated using a wheelchair with total assistance from staff due to his limited mobility and limited fine motor skills. The Service Recipient received nutrition via a gastric tube (G-tube) and had diagnoses of profound intellectual disabilities, cerebral palsy, unspecified tracheostomy, quadriplegia and spastic quadra paresis, microcephalus, seizure disorder, right hip dislocation, gastro esophageal disease, scoliosis of lumbar spine as well as other medical conditions and a history of PICA behaviors. (Hearing testimonies of Subject and [redacted] QI Specialist; Justice Center Exhibits 6-7, 9-10, 20-21 and 23)

8. On [redacted] the Service Recipient was hospitalized due to chronic respiratory failure. During his hospitalization, the Service Recipient had a tracheostomy tube implanted in the base of the front of his neck. Thereafter, the Service Recipient was discharged and returned to the facility on [redacted] Upon his return, the Service Recipient received new equipment including an oxygen concentrator apparatus and trachea mist collar. He also received a medical prescription for oxygen therapy that required him to receive continuous oxygen at a level of 2 liters per minute (LPM). (Justice Center Exhibits 6, 9-10 and 19-20)

9. The Service Recipient's oxygen concentrator apparatus (or oxygen source) consisted of many different oxygen tubes with various connections. The two oxygen tubes relevant in this case involve a small and large tube that separately connect at one end to the base of the oxygen concentrator. The other end of the large oxygen tube is connected directly to a humidification bottle (or humidification machine) and the other end of the small oxygen tube intersects with and is connected to the large oxygen tube. At this intersection point, the oxygen from the small tube is allowed to flow into the large oxygen tube to mix with distilled water

contained in the humidification bottle to form a mist that traveled to the Service Recipient's tracheostomy tube.[1] Ultimately, this process allowed the Service Recipient to receive oxygen while keeping his trachea collar moist. (Justice Center Exhibit 6, item 2 at pages 13-14; and Justice Center Exhibit 23 at page 3)

10. On the oxygen apparatus there was a white cap where the small tube intersects with the large tube. The white cap was adjustable for the purpose of opening and closing the oxygen/mist flow. With the white cap in the open position, the Service Recipient could receive a continuous supply of oxygen. With the white cap in the closed position or in the event the oxygen tubes became disconnected, then the Service Recipient's oxygen would be cut off. (Hearing testimonies of Investigator [redacted] and [redacted] QI Specialist; Justice Center Exhibit 6; and Justice Center Exhibit 23, photograph of the oxygen concentrator apparatus at pages 1-3)

11. Instructions for the Service Recipient's trachea and oxygen care were detailed in his Therap Individual Care Plan (ICP)[2] which was last updated on [redacted] Pursuant to the Service Recipient's ICP and bed check form, staff was mandated to conduct an inspection (bed check) every twenty minutes throughout the night to ensure that all of the Service Recipient's oxygen connections and equipment remained intact and properly functioning. After each inspection, staff was required to document the outcome of their checks on the "bed check form with oxygen" (the form). Bed check duties also required staff to track and verify the Service Recipient's oxygen levels by using the pulse oxygen monitor (pulse ox) attached to his foot and

[1] The tube connected directly to the Service Recipient's trachea mist collar is marked as tube #6 on the oxygen concentrator apparatus photograph as seen in Justice Center Exhibit 23 at page 1. (Hearing testimony of the Subject)

[2] The term "Therap" refers to an on-line computerized system that all staff can access to find essential documents relating to a service recipient's care. (Hearing testimony of [redacted], [redacted] QI Specialist)

then to document the results on the form. (Justice Center Exhibits 12 and 21)

12. On [redacted] the Subject was fully trained by Registered Nurse 2 (RN 2) regarding the complete set-up, connections and operation of the Service Recipient's new oxygen equipment. The Subject was specifically shown where the tubing was to be properly connected. The concentrator (or oxygen source) was to be connected to the humidification bottle and the humidification bottle was to be connected to the Service Recipient's tracheostomy. Additionally, as a part of the Subject's training session, it was explained why the Service Recipient needed continuous oxygen and emphasized that the source of oxygen must be continuous in order for the Service Recipient to properly receive the oxygen. All staff caring for the Service Recipient were required to attend the special oxygen equipment training. (Hearing testimony of [redacted], [redacted] QI Specialist and Justice Center Exhibit 6 at page 17; Justice Center Exhibits 16-17, 19-20; and Justice Center Exhibit 23 at pages 2-3)

13. The Service Recipient's bed/oxygen (O2) checks were required to be documented every twenty minutes throughout the night on the oxygen tracking form entitled "bed check form with oxygen" (the form). The paragraph at the top of the form included language in bold lettering that staff was required to "**[e]nsure that all medical equipment being used is hooked up and running properly**." The form specified that staff was to check the Service Recipient's oxygen connections then mark the "yes" box on the form in the column entitled "Tubing Connected To O2 Source" to confirm that the connections were properly in place or "no" if there was an oxygen connection that was displaced. (Justice Center Exhibit 12)

14. The Subject worked the overnight shift on [redacted] and was assigned to care for the Service Recipient and four other service recipients. (Justice Center Exhibit 22) At all bed/oxygen check times during her shift, the Subject checked "yes" and initialed the boxes on the

form in the oxygen connection column. (Hearing testimonies of the Subject and [redacted] QI Specialist; and Justice Center Exhibits 6, 11-14 and 22)

15. At approximately 2:40 a.m. on [redacted] a facility licensed practical nurse (LPN) had cleaned the Service Recipient's tracheostomy and observed that all of the Service Recipient's oxygen tubing connections were intact. The LPN then left the room. (Justice Center Exhibit 6, item 3 at page 14)

16. At approximately 3:00 a.m. that morning, the Subject conducted another bed/oxygen check of the Service Recipient. The Subject rolled the Service Recipient over to one side in order to replace his wet brief. At that time, she noticed for the first time that the white cap was open or uncapped. (Hearing testimony of the Subject, Justice Center Exhibit 6; and Justice Center Exhibit 23 at page 3) The Subject checked to verify that the large oxygen tube from the Service Recipient's humidification bottle to his mist collar/tracheostomy was still connected. The Subject failed to verify that any of the Service Recipient's other oxygen connections were intact and operational. Nevertheless, the Subject documented on the form that a complete check was performed. (Justice Center Exhibit 12 and hearing testimony of the Subject with notation #6 on the oxygen concentrator photograph at page 1 of Justice Center Exhibit 23)

17. The Subject then conducted the Service Recipient's next bed/oxygen check at approximately 3:20 a.m. when she again only inspected the tubing connection from the Service Recipient's humidification bottle to his tracheostomy. The Subject again documented on the Service Recipient's oxygen form that she had inspected all of the oxygen connections when she actually had not. (Hearing testimony of the Subject and Justice Center Exhibit 6)

18. At 3:36 a.m., the Subject administered the Service Recipient's medications and then closed the opened white cap effectively cutting off the Service Recipient's continuous oxygen

flow. (Justice Center Exhibits 12 and 23, pages 1-3)

19. At 6:00 a.m., DSP 2 was assigned to take over the care of the Service Recipient. DSP 2 completed her first bed/oxygen check of the Service Recipient at 6:20 a.m. She did not visually check to verify that the Service Recipient's oxygen connections from the humidification bottle to the oxygen concentrator were intact and she did not notice that the white cap had been closed or capped. Thereafter, at approximately 8:40 a.m., RN 1 reported to the Service Recipient's bedroom to assist DSP 2 with a different matter. When RN 1 entered the room, she observed that the large tubing, that was supposed to be connected from the Service Recipient's oxygen concentrator to the humidification bottle, was disconnected and lying on the bedroom floor. RN 1 also observed that the white cap on the tubing from the oxygen concentrator to the humidification bottle, which should have been opened or uncapped, was now closed or capped. The Service Recipient's oxygen levels, however, remained acceptable at all times throughout the incident. (Justice Center Exhibit 6, page 16; Justice Center Exhibit 6, pages 13-14; Justice Center 6, pages 16-17; and photograph of oxygen apparatus, Justice Center Exhibit 23, page 3)

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)(h) and states:

> "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…"

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

> 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.

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 acts of neglect cited in the substantiated report constitute the category of neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed the acts, described as "Allegation 1" and "Allegation 2" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-23) The investigation underlying the substantiated report was conducted by [redacted], [redacted] QI Specialist, hereinafter referred to as 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 sustain a finding of neglect, the Justice Center must establish by a preponderance of the evidence that the Subject engaged in conduct that breached her custodian's duty to the Service Recipient, and that this breach was likely to result in, physical injury or serious or protracted impairment to the physical, mental or emotional condition of the Service Recipient.

The Subject's duty of care to the Service Recipient required that she conduct timely bed/oxygen checks and that she properly document each bed/oxygen check on the form. (Hearing testimonies of Investigator [redacted] and the Subject; and Justice Center Exhibits 12 and 21)

Allegation 1 of the substantiated report alleges that the Subject failed to ensure and document that the Service Recipient's oxygen (or large oxygen tubing) was properly connected. Allegation 2 of the report alleges that the Subject cut off the Service Recipient's oxygen when she closed the white cap on the connector tube of the Service Recipient's oxygen source without seeking clarification as to whether that action was proper.

As to Allegation 1, the Subject admitted that she did not conduct a complete inspection of the Service Recipient's oxygen equipment during bed/oxygen checks although she affirmed on the form that she had performed a full inspection. (Hearing testimony of the Subject and Justice Center Exhibit 12)

As to Allegation 2, the Subject admitted that she closed the white cap, mistakenly believing that an opened white cap meant that the Service Recipient was losing oxygen. The Subject also admitted that she never sought clarification from the nurse regarding the proper positioning of the white cap. (Hearing testimony of the Subject, Justice Center Exhibits 6 and Justice Center Exhibit 23 at pages 1-3)

The Subject claimed that she misunderstood the [redacted] training instructions and that the training was insufficient. The Subject further asserted that this was the first time she was assigned to care for a resident with a tracheostomy. Finally, she argued that the term "neglect" did not apply to her because she did the best she could to care for the Service Recipient.

The Subject's assertions are not supported by the evidentiary record. RN2, who conducted the [redacted] training, and other staff members, who attended the training, were interviewed during the course of the investigation and provided credible accounts that the training regarding the Service Recipient's oxygen equipment was sufficiently detailed and adequate. (Justice Center Exhibit 6) The Subject's remaining assertions do not provide a justification absolving her of her failure to provide proper care to the Service Recipient.

However, the record does sufficiently support that the Subject breached her custodian's duty and committed neglect. The Subject failed to accurately document and ensure that the Service Recipient's oxygen equipment was properly connected. At 3:36 a.m., the Subject also capped off the white cap connector to the Service Recipient's oxygen without seeking clarification from the

nurse. Approximately four hours later at 8:40 a.m., registered nurse 1 (RN1) discovered the white cap closed and the large oxygen tube disconnected and lying on the Service Recipient's bedroom floor. As a result, the continuous supply of oxygen, which was medically ordered to assist the Service Recipient with his chronic respiratory failure, was halted. A significant period of time had elapsed before the defects in the oxygen connection were discovered and corrected. Consequently, the Subject's actions or inactions were likely to have resulted in 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 acts of neglect alleged. 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 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 2 act. The Subject's neglect deprived the Service Recipient of medically prescribed supplemental oxygen for several hours and this omission seriously endangered the health, safety or welfare of the Service Recipient.

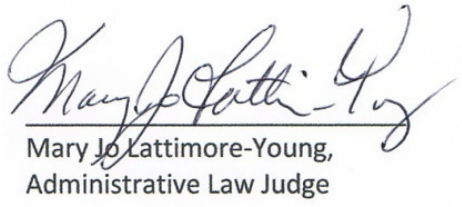
A substantiated Category 2 finding of abuse or neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged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

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 Category 2 acts.

This decision is recommended by Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: October 17, 2016
West Seneca, New York



Mary Jo Lattimore-Young,
Administrative Law Judge