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: Theresa Wells, Esq.

[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 shall be modified to be properly categorized as a Category 3 act.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

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: December 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: Elizabeth M. Devane
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
Adam Clayton Powell State Office Building
163 West 125th Street
New York, New York 10027
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
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By: Theresa Wells, Esq.

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [redacted] of neglect by the Subject of a Service Recipient.

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

Allegation 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to follow agency policies to ensure a service recipient received a new prescription in a timely fashion, necessitating a trip to the emergency room to treat hyperglycemia.
>
> 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] and is known as the [redacted]. The [redacted] is a residential facility providing services for adult females with developmental disabilities and is

operated by [redacted], which is a facility certified by the Office for People With Developmental Disabilities, which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Quality Improvement Investigative Specialist [redacted]; Justice Center Exhibit 6)

5. At the time of the alleged neglect, the Subject had been employed by [redacted] as a Direct Support Professional (DSP) for approximately two and one half years. The Subject was also Approved Medication Administration Personnel (AMAP) certified to dispense and administer medications to service recipients as needed. The Subject's duties included caring for the adult residents with developmental disabilities and assisting with day-to-day living activities as well as AMAP duties. (Hearing testimony of Quality Improvement Investigative Specialist [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 2 and 6)

6. At the time of the alleged neglect, the Service Recipient was 25 years old with diagnoses of autism, pervasive developmental disorder and severe intellectual disabilities. The Service Recipient used a combination of utterances and gestures to express her basic needs and wants and ambulated independently. (Hearing testimony of Quality Improvement Investigative Specialist [redacted]; Justice Center Exhibits 6 and 14)

7. The Service Recipient also had diabetes mellitus type1 and was insulin dependent. AMAP staff on duty administered insulin to the Service Recipient pursuant to her diabetes protocol. The Service Recipient received two types of insulin via needle, one that was long-lasting and the other that was fast-acting, and each was administered at specified times. (Hearing testimony of Quality Improvement Investigative Specialist [redacted] Justice Center Exhibits 6, 10, 11, 14 and 16)

8. According to [redacted] policy, medications are to be reordered/refilled ten

days in advance of the medication running out. However, should the last dose of a medication be administered, the AMAP on duty is expected to reorder that medication, as well as contact both the Nurse and the Residence Manager to inform them of the situation. (Hearing testimony of Quality Improvement Investigative Specialist [redacted]; Justice Center Exhibits 6, 8, 10 and 11)

9. According to [redacted] policy, if a medication is needed immediately, staff is to deliver the prescription in person to the backup pharmacy, Walgreens, and wait for it to be filled. Medication can also be reordered online. Medication errors include failure to fill a prescription in a timely manner and timeliness is defined by the supervising nurse or physician. The Subject attended an AMAP in-service meeting on [redacted] regarding medical protocols and safety; including the responsibility of the overnight staff for maintaining the Medication Inventory. (Hearing testimony of Quality Improvement Investigative Specialist [redacted]; Justice Center Exhibits 6, 8, 10, 13, 16 and 26)

10. At the time of the alleged neglect, the Subject was on duty overnight at [redacted] from 11:00 p.m. [redacted] to 8:09 a.m. [redacted]. The Subject was a custodian as that term is defined in Social Services Law §488(2). (Hearing testimony of Quality Improvement Investigative Specialist [redacted] Hearing testimony of the Subject; Justice Center Exhibits 6, 10, 13 and 20)

11. Between 6:30 a.m. and 7:30 a.m. on [redacted], the Subject, as the AMAP on duty, prepared to administer the long-lasting insulin to the Service Recipient. The Subject saw that there was only one dose of the long-lasting insulin left and was told by staff [redacted] that there was no "back up" insulin available. The Subject administered the last remaining dose of long-lasting insulin in the residence to the Service Recipient. The fast-acting insulin was available at the

residence. The Service Recipient was due to receive the next dose of long-lasting insulin at 6:00 p.m. Staff [redacted] was the medical coordinator on duty and told the Subject she would reorder the long-lasting insulin when the pharmacy, [redacted] which was located in [redacted] and was closed at the time, reopened at 9:00 a.m. (Hearing testimony of Quality Improvement Investigative Specialist [redacted]; Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 10, 13 and 20)

12. The Subject left her shift for the day at 8:09 a.m. on [redacted] without reordering the insulin and without informing the Residence Manager or Nurse that she gave the Service Recipient the last available dose of long-lasting insulin. (Hearing testimony of Quality Improvement Investigative Specialist [redacted] Hearing testimony of the Subject; Justice Center Exhibits 6, 7, 10 and 20)

13. Staff [redacted] placed a rush reorder to ChemRx for the long-lasting insulin at 9:49 a.m. on [redacted]. (Hearing testimony of Quality Improvement Investigative Specialist [redacted]; Hearing testimony of Subject; Justice Center Exhibits 6, 10 and 18)

14. Staff [redacted] arrived to work at 4:00 p.m. on [redacted], and upon her arrival was told by Staff [redacted] that the long-lasting insulin was ordered but had not yet been delivered. At 5:30 p.m., Staff [redacted] contacted the Nurse as she checked the Service Recipient's sugar levels and they were elevated. The Service Recipient was due for her next dose of long-lasting insulin at 6:00 p.m. and there was no long-lasting insulin on site as it had not yet been delivered. The insulin was not delivered until the following day and [redacted] apologized for the delay. (Hearing testimony of Quality Improvement Investigative Specialist [redacted] Justice Center Exhibits 6, 7 and 9)

15. The Nurse told Staff [redacted] to take the Service Recipient to the emergency room due

to her elevated sugar levels and due to the fact that there was no record of what the Service Recipient ate and drank that day. The Service Recipient was admitted to the hospital overnight and was diagnosed with Hyperglycemia. The Service Recipient was treated with insulin and intravenous fluids. (Hearing testimony of Quality Improvement Investigative Specialist [redacted]; Justice Center Exhibits 6, 7, 9, 11 and 15)

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 neglect.
- Pursuant to Social Services Law § 493(4), the category of 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 neglect of a person in a facility or provider agency is defined by SSL § 488(1) (h), to include:

> "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs

> (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of neglect shall be categorized into categories pursuant to SSL § 493(4), including 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 an act, described as "Allegation 1" in the substantiated report.

In order to sustain an allegation of neglect, the Justice Center must show that the Subject acted, or failed to act, or lacked attention in such a manner that it breached her duty to the Service Recipient. In addition, the Justice Center must show that this breach either resulted in, or was likely to result in either physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1- 27) The investigation underlying the substantiated report was conducted by [redacted] Improvement Investigative Specialist [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.

The Subject, a DSP at [redacted], was a custodian as that term is defined in Social Services Law §488(2). The Subject was aware when she administered the dose of long-lasting insulin to the Service Recipient that it was the last dose of the medication available at [redacted]. According to [redacted] policy, the Subject had three duties at that juncture. The Subject needed to refill the medication and was required to notify both the Nurse and House Manager that the last remaining dose on site was administered. The Subject admitted at the hearing that she failed to act and that she did not personally refill the prescription, she did not notify the Nurse and

she did not notify the Residence Manager that the last dose of long-lasting insulin medication was administered.

The Subject argued that the pharmacy did not open until 9:00 a.m., after her shift was over, and that her co-worker, Staff [redacted], who was also the medical coordinator on duty, volunteered to order the insulin herself, and did do so, once the pharmacy opened. Further, [redacted] Policy mandates that medications be reordered 10 days prior to the administration of the last dose. The Subject had returned to work for her shift from 11:00 p.m. [redacted] to 8:09 a.m. [redacted] after being off for five days and during that time the prescription was not reordered by any party. The pharmacy, [redacted], which was a long distance away, accepted the blame in a fax letter for failing to deliver the medication in a timely manner and offered an apology. (Justice Center Exhibit 17)

The Subject's arguments fail regarding the allegation of neglect. The Subject failed to follow the proper protocols and procedures and the Subject admitted that she should have called the Nurse and/or Residence Manager. The Subject also had a duty under the agency protocols to refill the medication herself, despite the fact that staff [redacted] offered to do so. While the pharmacy was not open, the Subject could have gone in person to Walgreens, the alternate pharmacy that staff was to go to in such situations, or ordered the medication online. Importantly, had the Subject contacted the Nurse or Residence Manager, they could have given her further direction in regard to reordering the medication, however, she failed to contact either party.

Quality Improvement Investigative Specialist [redacted] testified that when a person does not receive their prescribed insulin at specified times, there is the risk of their blood sugar levels being off which can cause health problems. She added that diet is also a factor in blood sugar levels. Therefore, not having the necessary insulin available could likely result in physical

injury or serious or protracted impairment of the physical condition of a 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.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. The report was substantiated a Category 2 neglect. To prove Category 2 conduct, the Justice Center must establish that the Subject's conduct "seriously endanger[ed] the health, safety or welfare of [the] service recipient…" (SSL §493(4)(b)) by committing the act of neglect.

Allegation 1 states that the Subject's neglect necessitated "a trip to the emergency room to treat hyperglycemia." That is not accurate. The Service Recipient's trip to the emergency room was not necessitated by the Subject's failure to follow agency policies to ensure the Service Recipient received a new prescription in a timely fashion. Evidence showed that the Service Recipient's trip to the emergency room was necessitated by the high range of her blood sugar level and the fact that there was no record of what the Service Recipient ate and drank that day. The short acting insulin was available on site and could have been administered to prevent a blood sugar spike. The Nurse stated even if the long-lasting insulin were on site, it could not have been administered to the Service Recipient at that point and she would have directed that the Service Recipient be taken to the emergency room in any case based upon her blood sugar level and unknown diet that day. Quality Improvement Investigative Specialist [redacted] concluded that a "system breakdown" occurred. The Subject's inactions were not the sole cause for the neglectful situation and, in fact, a number of protocols were not followed by a variety of staff which led to the medication not being on site. In any event, even if the long-lasting insulin were on site at the

time, the Service Recipient would have been sent to the emergency room. Therefore, while the Subject was neglectful in not following protocol, there is no evidence that her specific actions seriously endangered the health, safety or welfare of the Service Recipient and necessitated the trip to the emergency room.

Category 3 is neglect that is not otherwise described in categories 1 and 2. Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report of neglect does not rise to the level of Category 2, but instead is properly categorized as a Category 3 act. Substantiated Category 3 findings 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 SSL § 496 (2). The report will be sealed after five years.

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

The substantiated report shall be modified to be properly categorized as a Category 3 act.

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: November 25, 2016
Schenectady, New York

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Elizabeth M. Devane, ALJ