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: Laurie Cummings, Esq.

[redacted]
By: [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] of neglect by the Subject of a Service Recipient 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 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: March 20, 2017
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: New York State Justice Center for the Protection of People with Special Needs
Administrative Hearings Unit
401 State Street
Schenectady, New York 12305
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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New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Laurie Cummings, Esq.

[redacted]
By: [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 that there was oxygen in a service recipient's portable oxygen tank prior to transporting him to a medical appointment.
>
> 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 is an [redacted] for adult individuals with developmental disabilities, located at [redacted] and is operated by [redacted] (Hearing testimony of [redacted] Investigator [redacted]), and is

regulated 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.

5. At the time of the alleged neglect, the Subject was employed as a Residential Specialist, which is a direct care position. (Hearing testimony of [redacted] Investigator [redacted]) The Subject had been employed by the provider agency on a part-time basis for several years and had been assigned to the facility for approximately one year. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. The Service Recipient is a male in his sixties with a history of brain damage, chronic spinal cord compression and a Downs syndrome diagnosis. To assist him with breathing, the Service Recipient wore a cervical collar to maintain proper airway alignment. (Hearing testimony of [redacted] Investigator [redacted])

7. The Service Recipient's Individualized Plan Of Protective Oversight (IPOP), which was updated on [redacted], dictated that the Service Recipient was to receive oxygen therapy at a rate of two liters per hour, except when he was being transferred, at which time he could be removed from oxygen for short periods. (Justice Center Exhibit 15 and Hearing testimony of [redacted] Investigator [redacted])

8. A paper copy of the Service Recipient's Individual Care Plan (ICP) was maintained at the facility. This document functioned as the facility's continuous oxygen protocol. (Hearing testimony of [redacted] Investigator [redacted]) The ICP described, in general terms, oxygen therapy, oxygen tanks, oxygen concentrators, replacement of oxygen-depleted tanks, administration of the nasal cannula, and adjustment of flow meters. (Justice Center Exhibit 13) The ICP was also available to facility staff on-line, but there was no documentation confirming

that the Subject ever reviewed the ICP in any format. (Hearing testimony of [redacted] Investigator [redacted])

9. The Service Recipient's individual data record contains the Service Recipient's medical information and medical orders. At the time of the alleged neglect, the data record, indicated, in relevant part, "[e]nsure when going out of residence that at least 2 FULL oxygen tanks are with [the Service Recipient.] More if anticipated longer stretch of time." (Justice Center Exhibit 18, p. 3 and Hearing testimony of [redacted] Investigator [redacted]) The data record was stored and available in paper format in the facility. This document was also available in some electronic formats. (Hearing testimony of [redacted] Investigator [redacted])

10. On a daily basis, a specific facility staff person was assigned to the Service Recipient. At fifteen-minute intervals, the assigned staff was required to verify that the Service Recipient was receiving oxygen. From time to time, before the alleged neglect, the Subject was assigned to the Service Recipient and performed fifteen-minute checks to verify that he was receiving oxygen. (Hearing testimony of the Subject)

11. When in the facility, the Service Recipient received oxygen from a tube that was placed in his nose. The tube or hose was attached to one of two metal oxygen tanks that were mounted to the rear of the Service Recipient's wheelchair. When the Service Recipient went into the community, he received oxygen therapy with the same equipment. (Hearing testimony of the Subject) A circular gauge was mounted on the oxygen tank. On the far left of the gauge was the word "Refill" and on the far right of the gauge was the word "Full." (Justice Center Exhibit 21 and Hearing testimony of [redacted] Investigator [redacted]) During times when the Subject was assigned to and responsible for fifteen-minute checks to verify that the Service Recipient was receiving oxygen therapy, she would listen for the distinct sound of oxygen flowing through the

tube and, if needed, she would re-insert the tube into the nostrils of the Service Recipient. (Hearing testimony of the Subject)

12. The Subject attended a training on [redacted], which included training on the "Nursing Care Plan" for the Service Recipient. The training was provided by the facility RN. (Hearing testimony of [redacted] Investigator [redacted] and Justice Center Exhibit 17, third page) During this training, the facility RN reviewed all of the facility service recipients' care plans including the Service Recipient's "O2 plan." However, the facility RN did not explain how to change or hook up oxygen bottles. (Justice Center Exhibit 5, p. 6) The Subject did not receive training for reading the gauge on the oxygen tank. (Hearing testimony of the Subject and Hearing testimony of [redacted] Investigator [redacted])

13. On [redacted], at about 9:00 a.m., while preparing the Service Recipient for transport from the facility to a medical appointment, Staff 1 and Staff 2 discovered that the Service Recipient was not receiving oxygen via nasal cannula tube, as the tube was not connected to his nose. Staff 1 reconnected the Service Recipient's oxygen nasal cannula. The Subject and Staff 1 assisted the Service Recipient with dressing. Staff 1 read the oxygen gauge and determined that the tank was one-half full. (Justice Center Exhibit 5, p. 7) Although the Subject was not in the room when Staff 1 read the oxygen gauge, she was nearby and overheard Staff 1 tell Staff 2 that there was no worry about the oxygen level, because she had checked it. (Hearing testimony of the Subject and Justice Center Exhibit 5, p. 7) While the Subject remained in the facility, Staff 2 assisted the Service Recipient into the van. (Justice Center Exhibit 5, p. 7)

14. Sometime thereafter, but no later than 9:17 a.m., the Service Recipient, Staff 2 and the Subject departed from the facility in the facility van for the medical appointment. (Justice Center Exhibit 5, p. 6) The drive to the medical office was relatively short. (Hearing testimony

of the Subject and Hearing testimony of [redacted] Investigator [redacted]) The facility van arrived at the medical appointment at approximately 9:30 a.m. The facility RN was waiting outside for the Subject, Staff 2 and the Service Recipient to arrive. The facility RN examined the Service Recipient's oxygen gauges and determined that the oxygen tanks were empty. (Justice Center Exhibit 5, p. 7)

15. However, the Service Recipient's blood oxygen levels were checked in the physician's office and were determined to be at 98%. (Justice Center Exhibit 5, p. 5) The Subject asked the facility RN if she should go back to the facility and retrieve full oxygen tanks, but the facility RN told her not to do this, as he concluded that the appointment would take less time than the round trip to the facility to retrieve more oxygen. (Hearing testimony of the Subject and the Hearing testimony of [redacted] Investigator [redacted])

16. At approximately 9:55 a.m., the Subject, Staff 2 and the Service Recipient departed from the medical appointment for the return trip to the facility. (Justice Center Exhibit 5, p. 6) At the time of departure from the physician's office, the Service Recipient's blood oxygen levels were determined to be 94%. After his arrival back at the facility, the Service Recipient's blood oxygen levels were measured and were determined to have dropped to 78%. However, the Service Recipient was placed on oxygen and his blood oxygen levels rose to 94%. (Justice Center Exhibit 5, p. 5) Sometime later that day, the Service Recipient began to have breathing problems, was transported to the hospital and was diagnosed with a urinary tract infection. (Justice Center Exhibit 5)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.

- Whether the substantiated allegations constitute abuse or neglect.
- 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 neglect of a person in a facility or provider agency is defined by SSL § 488 (1)(h), 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)(c), 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 established by a preponderance of the evidence that the Subject committed the prohibited act described in "Allegation 1" 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 1-22) The investigation underlying the substantiated report was conducted by Investigator [redacted], Quality Management Coordinator of the [redacted] (the [redacted] Investigator), 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.

A finding of neglect requires that a preponderance of the evidence establishes that the Subject engaged in conduct that breached her duty to a service recipient and that the breach of duty

resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the service recipient.

The Service Recipient's individual data record contains the Service Recipient's medical information and specifically directs staff to: "[e]nsure when going out of residence that at least 2 FULL oxygen tanks are with [the Service Recipient.] More if anticipated longer stretch of time." (Justice Center Exhibit 18, p. 3) The Subject testified that she was unaware of the specific requirement that the Service Recipient was not to leave the house without two full oxygen bottles. However, the Subject's hearing testimony on this point is not credited evidence. Additionally, the Subject had experience completing fifteen-minute checks to verify that the Service Recipient was receiving oxygen in the facility and must have been aware that the Service Recipient required continuous oxygen therapy. After considering all of the evidence it is concluded that the Subject had a duty to ensure that the Service Recipient was receiving supplemental oxygen therapy.

In this case, the issue is whether the Subject failed to ensure that there was oxygen in the Service Recipient's portable oxygen tank prior to transporting him to a medical appointment. There is conflicting evidence as to whether the Subject was trained in how to replace depleted oxygen tanks. However, the evidence in the record supports the conclusion that the Subject's training included "Nursing Care Review" and the "care plans," (Justice Center Exhibit 8, first page and Hearing testimony of [redacted] Investigator [redacted]) and, specifically, that she received training in the Service Recipient's "O2" plan. (Justice Center Exhibit 5, p. 6)

The "O2 care plan" plan provides instructions for turning on the oxygen, listening for the sound of flowing oxygen, setting the appropriate flow rate and connecting the nasal cannula to the Service Recipient's nose. (Justice Center Exhibit 5, p. 4)

The Subject testified that she fulfilled her obligation to ensure that there was oxygen in the tank when she overheard Staff 1 say that the Service Recipient's oxygen tank was all set, sometime before departure. However, the Subject took no affirmative step to ensure that the Service Recipient had oxygen in his tank at the time of departure. Even accepting the Subject's argument that she was never trained to the read the gauge as true, by the Subject's own admission at the hearing, she was capable of assessing whether the Service Receipt was receiving oxygen by listening for the distinct sound of oxygen flowing from the nasal cannula tube into the Service Recipient's nose.

The Subject was still inside the residence when Staff 2 loaded and secured the Service Recipient in the van, however the evidence established that when the Subject entered the van that she failed to take any affirmative action to ensure that the Service Recipient was receiving oxygen, such as listening for the distinct sound of oxygen flowing through the nasal cannula tube.

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.

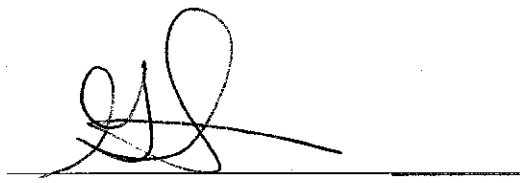
The report will remain substantiated and the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] of neglect by the Subject of a Service Recipient 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 a Category 3 act.

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

DATED: March 15, 2017
Schenectady, New York



Gerard D. Serlin, ALJ