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** **ADJUDICATION CASE** [redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived.

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Thomas Parisi, 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 [redacted] dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse.

The substantiated report properly categorized as a level three category.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Person's 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: Schenectady, New York
October 31, 2014

David Molik
Administrative Hearings Unit

[redacted]

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** **ADJUDICATION CASE** [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
11 Perlman Drive
Spring Valley, NY 10977
[redacted]

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived.

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Thomas Parisi, Esq.

[redacted]

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (hereinafter "the VPCR") maintains a report substantiating [redacted] (hereinafter "the Subject") for abuse and 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.

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 [redacted], dated [redacted] of neglect and abuse in the deliberate and inappropriate use of restraint by the Subject against service recipient [redacted]

2. The initial report alleges, in pertinent part, that on or about [redacted], [redacted] committed an act of neglect and abuse at [redacted], when he inappropriately ordered that [redacted] be given an intramuscular injection (IM) of psychiatric medication (Olanzapine and Ativan) STAT over her objection. (Justice Center Exhibit 4 and Exhibit 5)

3. The initial report was made to the Justice Center for the Protection of People with Special Needs (hereinafter "the Justice Center") and the Office of Mental Health Risk Management Department on [redacted] and was investigated by the Office of Mental Health Risk Management Department.

4. On or about [redacted], the Justice Center substantiated the report against the Subject for *abuse and neglect*. The Justice Center concluded that:

[redacted]

Offense 1

> On [redacted], at the [redacted], located at [redacted], while acting as custodian, you neglected a service recipient and authorized the use of a deliberate and inappropriate restraint when you ordered for a service recipient to receive a STAT medication in violation of facility policy.
>
> This allegation set forth above has been SUBSTANTIATED as Category 3 neglect and deliberate and inappropriate use of a restraint, pursuant to Social Services Law § 493.

5. An Administrative Review was conducted and as a result, the substantiated report was retained.

6. At the time of the alleged neglect and abuse the Subject was employed as a psychiatrist by [redacted] (hereinafter "the facility"), located at [redacted]. The facility is an *agency* or *provider* that is subject to the jurisdiction of the Justice Center. At the time of the alleged neglect and abuse the service recipient [redacted] was a patient at [redacted] in unit [redacted], the unit of which the Subject was the Medical Director. (Justice Center Exhibit 4 and Exhibit 5)

7. [redacted] had been admitted to the facility on [redacted], approximately six weeks prior to the date of the incident at issue. She had consistently refused any type of medication and was a loud and disruptive patient who had also been involved in more than one incident of fighting. During her period of committal, she had already been subjected to twenty-two STAT IM medications over her objection, and nine Restraints/Seclusions. (Justice Center Exhibit 5)

8. On the morning of [redacted], [redacted] was participating in a Community Meeting in a dayroom at the facility that was being run by her assigned psychiatrist, [redacted]

[redacted]. The topic of discussion was the issue of safety and smoking in the facility with the patients who were in attendance. (Justice Center Exhibit 8)

9. At the time the dayroom was noisy, with [redacted] contributing to the noise by being argumentative, hostile and disrespectful towards [redacted] (Justice Center Exhibit 13)

10. During the Community Meeting, the Subject, [redacted], who had heard the noise while on rounds in the Unit, went into the dayroom and observed the patients, some of whom were being loud and disruptive. He concluded that [redacted] was angry, hostile and aggressive. However, [redacted] did not speak directly to [redacted] He then approached [redacted] and questioned her about the status of facility's Medication Over Objection application for [redacted] He suggested that [redacted] write an order for IM psychiatric medication for [redacted] to calm her down. [redacted] declined to do so citing her concern that [redacted] had already been calling CQC and her concern of involvement with the Justice Center. [1](Justice Center Exhibit 9)

11. [redacted] then inquired if he could write the order and [redacted] replied that "that would be fine." (Testimony of [redacted]; Appellant)

12. Without further discussion, [redacted] wrote the order and gave it to nurse [redacted], who was the one who ultimately administered the medication. She and other staff then approached [redacted], who was seated in the dayroom, where [redacted] had first observed her, to carry out the order. It soon became apparent to [redacted] by the staff's conduct that she was about to be medicated. [redacted] began questioning why she was being medicated, insisting that she was already calm. Throughout the conversation she was and

[1]There were some discrepancies in the record regarding where [redacted] and [redacted] spoke and as to how many times they spoke that morning but these facts are irrelevant to the determination of the issues in this case.

[redacted]

remained in a seated position. She asked to speak with the doctor that made the order before the medication was given.

13. One of the staff went to locate [redacted] and accompanied him back to the dayroom for him to speak to [redacted] At that point there was some discussion between [redacted] and [redacted] about her need for medication. [redacted] was angry and upset but remained in a passive seated position on the floor insisting that she did not need, or want to be medicated. After a short exchange, [redacted] was not persuaded by [redacted] to retract the order. He told the staff to give the medication and exited the room. (Justice Center Exhibit 5)

14. The staff then followed protocol by bringing a mattress into the dayroom, as [redacted] refused to move, rolling her onto the mattress and physically restraining her to assist [redacted] in giving the injection without injury to [redacted] or staff. (Hearing Testimony of [redacted])

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 level of abuse that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse or neglect in residential care facilities. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse or neglect presently under review was substantiated. A "substantiated report" means a report made "… if an investigation determines that a preponderance of evidence of the alleged neglect and/or abuse exists."

[redacted]

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: 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, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse or neglect; and pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

The abuse and neglect of a person in residential care is defined by SSL § 488:

1. "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:

   (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.

   (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

   (c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of

a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use

[redacted]

by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(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.

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 abuse or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category level of abuse and neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

(a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

(i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious

disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;
(ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;
(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;
(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;
(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;
(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;
(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;
(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;
(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably

[redacted]

foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;
(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;
(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;
(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and
(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(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.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse, 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 abuse cited in the substantiated report constitutes the category level of abuse set forth in the substantiated report. The Justice Center will inform any inquiring licensing or provider agency that the Subject is substantiated in the report. If applicable, its existence is subject to

[redacted]

disclosure to licensing and provider agencies making inquiry concerning the Subject pursuant to SSL §§ 495(2) and 424-a.

If the Justice Center did not prove the abuse by a preponderance of evidence, the substantiated report must be amended and sealed. Its existence will not be disclosed to licensing and provider agencies.

DISCUSSION

The Justice Center has succeeded in establishing by a preponderance of evidence that the Subject, [redacted], did commit the abuse as alleged in the substantiated report. The category level of abuse that such act or acts constitute is appropriately a Category 3 offense.

In support of its indicated findings, the Justice Center presented a number of documents obtained during the course of investigation. (See Justice Center Exhibits 1-16) The investigation underlying the substantiated report was conducted by [redacted], an investigator employed by the Office of Mental Health Risk Management Department. Testifying for the Justice Center at the hearing were Social Worker, [redacted], Investigator and Director of Risk Management, [redacted] and facility staff psychiatrist, [redacted]. [redacted] also interviewed and obtained the written statements of the Subject, [redacted], the service recipient, [redacted], her psychiatrist, [redacted], RN [redacted], RN [redacted], MHTA [redacted], LCSW [redacted], MHTA [redacted] and psychology intern [redacted].

[redacted] testified on his own behalf and called Chief of Service Admissions, [redacted] and fellow facility psychiatrist [redacted] as his witnesses. He introduced three exhibits into evidence. (See Subject Exhibits 1-3)

The Justice Center primarily relied on the provisions of [redacted] Hospital Policy and Procedure Manual regarding the use of psychiatric STAT medications

[redacted]

together with evidence that [redacted] behavior did not warrant the use of medication at the time in question.

[redacted] Hospital Policy & Procedure Manual Topic: Use of Psychiatric STAT Medications (Justice Center Exhibit 7) states that:

> Patients have the right to refuse any and all aspects of care, including medication. Medication can be given to a patient over their objection in only two ways: 1) when the patient's symptoms and behavior pose a significant threat to self or others or 2) as a result of a valid medication over objection order from the court.

There was a great deal of focus during the testimony of witnesses as to the meaning of the words "significant threat to self or others" as meant in the above referenced statement of facility policy.

[redacted] primarily relied on a two pronged argument that involves a broad interpretation of the words "significant threat to self or others" together with evidence that he was simply following the orders of his superior, [redacted] as a defense to his actions.

[redacted] and his witness, [redacted] testified that they interpret "significant threat to self or others" to include any loud or disruptive behavior that might conceivably escalate into violence or cause retaliation by other patients which could potentially escalate into a violent or dangerous conflict or fight.

[redacted] stated repeatedly and emphatically that he was exhorted on a daily basis by the Director of the facility, his supervisor, [redacted], who did not tesitify, to "treat" the patients, to maintain a calm environment, and to keep the units quiet. He stated that he was regularly told by [redacted] to be proactive and use the green sheet (the STAT Psychiatric Medication Progress Note, Subject Exhibit1), whenever necessary to protect fragile patients from the effects of the loudness and agitation of the other patients. [redacted] further testified that behavior that could agitate the other patients in the unit could be unsafe and fits within the

[redacted]

language of "significant threat to self or others." Ultimately, according to [redacted], the determination of whether conduct constitutes a "significant threat to self or others" is based on the Doctor's own clinical judgment.

The desirability to maintain a calm and quiet environment is understandable. However, it is a very slippery slope upon which to tread when one applies such a broad, flexible and subjective interpretation to "significant threat to self or others," particularly in light of the substantial deprivation of the patient's liberty, and the considerable invasion of their person that occurs when an intramuscular injection of psychiatric medication STAT over objection is administered.

It is clear that [redacted] interpretation is not consistent with the simple language of [redacted] Hospital Policy & Procedure Manual. There must be some tangible and articulable threat to constitute "significant threat."

This leads to the controversial question of what exactly [redacted] was doing to warrant an order for her to receive psychiatric STAT medications at the time that [redacted] decided that she needed to be medicated.

[redacted] statement reports that [redacted] was "loud, rude, insulting and sarcastic." He felt that patients on the unit were being highly agitated by her behavior. However, when asked by the investigator if she was threatening anyone he responded with "no."

[redacted] testified at the hearing that [redacted] was screaming very loudly and that no one else could say anything. She was monopolizing the discussion and that everyone else was intimidated by her. He said that she was displaying classic signs of mania.

Some of the witnesses were unable to provide any evidence about [redacted] behavior in the dayroom immediately prior to [redacted] order, as they were not present at the time.

[redacted] was present and her statement was that, during the Community Meeting,

[redacted] was particularly hostile and angry with her [redacted], with some verbal aggression but that by the time the meeting ended, [redacted] had walked away and was sitting on a chair at the back of the dayroom. [redacted] further indicated that had [redacted] not been there, she would not have given [redacted] an injection but she would have offered her oral medication. (See Subject Exhibit 9)

Psychology intern [redacted] was present and her statement was that [redacted] was very obnoxious, saying negative things to [redacted] but that [redacted] did not display any aggressive behavior, nor was she threatening anyone. When asked if she felt that [redacted] required medication, her response was "no, not at that time." (See Subject Exhibit 15)

Lastly, LCSW [redacted] was present and her statement is that [redacted] was loud and argumentative towards [redacted] but she was not threatening. She also indicated that she did not think that [redacted] required medication at that time.

At the time that [redacted] decided that she needed to be medicated, [redacted] behavior did not meet the threshold of "significant threat to self or others." [redacted] was in the dayroom for just a short period of time and had not approached [redacted] or spoken to her to properly determine whether she was, in fact, a "significant threat to self or others." [redacted] statement indicates that [redacted] did have "an outburst" in [redacted] presence but that she went to the back of the day room without further incident thereafter. In any case, even if [redacted] behavior at that time was as described by [redacted] himself, her behavior did not meet the threshold test as a "significant threat to self or others."

Subsequent to making the order, [redacted] had the opportunity to reevaluate if his order was appropriate when he was called to the dayroom to speak with [redacted] By that point, he had continued with his duties on the unit while some of the staff, including [redacted] prepared to administer the medication. When the staff

[redacted]

approached [redacted], who was sitting in a chair, still in the dayroom, she was incredulous that the order had been made and demanded to speak with the doctor. A staff member went out to get [redacted] and [redacted] returned to the dayroom to speak with [redacted] At some point [redacted] moved from the chair and was sitting on the floor when [redacted] came into the room. [redacted] statement and testimony are consistent in that he reported that [redacted] was screaming, cursing and using abusive language when he came into the room. He spent a few minutes with her and then exited the room, reiterating his order for the medication.

[redacted] testified credibly at the hearing that from the time that he went into the dayroom to help the other staff with [redacted], after the order was originally made until after [redacted] came and went, [redacted] was seated and calm, only upset because the medication had been ordered.

Again, even according to [redacted] version of events, the standard of "significant threat to self or others" was not met. While [redacted] may have been rude and insulting, she was sitting down on the floor cross legged throughout the verbal exchange. The order should have been retracted by [redacted] at that point.

[redacted] stated to the investigator and testified doggedly that he was simply following the instructions of his superior, [redacted] to be proactive in giving medication to keep the units quiet, calm and agitation-free. [redacted] testimony strongly corroborated [redacted] evidence but also seemed to be so seamlessly supportive of his case, as to lose its credibility as independent and disinterested.

[redacted] testified that she was often present with [redacted] during the morning rounds and that while she understood [redacted] encouragement to get the patients to take medication, she did not think that he meant that doctors should administer STAT psychiatric medication over the objection of patients inappropriately.

[redacted]

In this case, the evidence given by [redacted] regarding [redacted] instructions is not convincing. It was in [redacted] self-interest to exaggerate the order to medicate and, in any case, even if [redacted] had created a culture of forcing medication on patients, [redacted] explanation that he was just following orders is not a legitimate defense under the Statute.

[redacted] also introduced as his evidence (Subject's Exhibits 1 and 2) two forms that are used to document the administration of psychiatric medication over a patient's objection at the facility. Although they are different forms for different circumstances, there existence does not provide for any exception to or variation from the facility policy and therefore, they are not particularly helpful.

[redacted] also relied on the fact that subsequent to the Office of Mental Health investigation, some aspects of facility policy were reviewed and revised. However, the evidence was that the stated criteria as set out in the [redacted] Hospital Policy & Procedure Manual, that is the focal point of this proceeding, was not changed in the revision process.

Lastly, [redacted] relies on the fact that the facility was granted Medication Over Objection Order by the Court for [redacted] after this incident as justification for his use of medication in this case. However, the fact is that at the time that [redacted] ordered [redacted] medicated on [redacted], there was no such order in place and the subsequent existence of the order does not remedy violations of facility policy retroactively.

In the final analysis the question of whether [redacted] has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report is undisputed. He admitted to ordering that [redacted] be given an intramuscular injection (IM) of psychiatric medication (Olanzapine and Ativan) STAT over her objection.

[redacted]

The evidence further shows that the acts committed by [redacted] did constitute abuse under SSL§488(1)(d) as a deliberate inappropriate use of pharmacological restraints that was inconsistent with the [redacted] Hospital Policy & Procedure Manual. The language of SSL§488(1)(d) is very specific and clearly contemplates the type of situation as has arisen in this case.

Lastly, pursuant to Social Services Law § 493(4), the substantiated allegation did constitute a Category 3 level of deliberate and inappropriate use of restraint. [redacted] order of intramuscular injection of psychiatric medication STAT over objection was a violation of SSL § 488(1)(d), being a deliberate inappropriate use of restraints and, as such, was appropriately found to be Category 3 conduct.

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 abuse alleged. The substantiated report will not be amended. A substantiated Category 3 finding of abuse or neglect will not result in the Subject 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.

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

[redacted]

The substantiated report properly determined that the Subject's abuse of the service recipient constituted Category 3 conduct.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Bureau.

DATED: October 15, 2014
Spring Valley, New York