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: Jennifer Oppong, Esq.

[redacted]

By: Michael E. Catalinotto, Jr., Esq.
Maynard, O'Connor, Smith & Catalinotto, LLP
3154 Route 9W, PO Box 180
Saugerties, New York 12477

[redacted]

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

ORDERED: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed is 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 2 act.

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: July 26, 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: David Molik
Supervising Administrative Law Judge

Held at: New York State Justice Center for the Protection Of People With Special Needs
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
Appearance Waived.

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:

Offense 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 the door to a cleaning/utility room was closed. As a result, a service recipient was able to enter the closet, obtain razors and use the razors to attempt suicide by cutting his arms.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493.

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

4. The facility, located at [redacted], is a hospital certified by the Department of Health (DOH) and licensed by the Office of Mental Health (OMH),

[redacted]

and is a facility or provider agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 4, and Hearing testimony of Investigator [redacted]).

5. At the time of the incident, the Subject had been employed by [redacted] for approximately six years as a Mental Health Assistant (MHA). His duties include doing rounds, taking patients' vitals, transporting patients, conducting body searches and other basic direct-care tasks as assigned by the nursing staff. (Hearing testimony of Subject).

6. At the time of the alleged neglect, the Service Recipient was a 43 year male diagnosed with major depressive disorder with psychotic features, opiate abuse, borderline personality disorder, insulin-dependent diabetes mellitus and hypertension. He had been admitted to the Psychiatric Unit following an attempted suicide by insulin overdose. In the days leading up to this incident, the Service Recipient had engaged in self-injurious and opiate seeking behaviors. On [redacted], the Service Recipient eloped during a court appearance and subsequently returned to the hospital to retrieve his belongings. At that time, he was re-admitted and placed on Suicide Precautions (SP) status until [redacted], when he assured his treatment team that he would comply with his treatment and behave appropriately. (Justice Center Exhibits 6, 11, 12 and 14).

7. On [redacted], the Subject worked from 3:00 p.m. until 11:30 p.m. He was assigned to take the vitals of the patients on the unit. At 7:23 p.m., the Subject entered the clean utility room using a key and then exited the room with the vitals cart. As he left, he pulled on the doorknob to make sure that the door was locked. At 7:38 p.m., the Subject entered the clean utility room with the cart and then exited without the cart. He walked quickly down the hall without pausing, without ensuring that the door was locked; and, in fact, the door was visibly ajar. At 7:42 p.m. the Service Recipient walked toward the clean utility room, saw that the door was ajar, looked

around, and went into the room. He left shortly thereafter, pulling the door closed behind him. No other person went into the clean utility room between 7:38 p.m. and 7:42 p.m. (Justice Center Exhibit 10).

8. Shortly after 8:00 p.m., the Subject received a call from MHA , who was assigned to do room checks. MHA had found the Service Recipient bleeding from self-inflicted wounds on both his forearms. The Service Recipient's left arm was significantly more deeply cut than the right arm, so MHA wrapped the Service Recipient's left arm in a blanket and applied pressure to try and stop the bleeding. RN also responded to MHA call for assistance. The Service Recipient told RN how he had cut himself and that he had taken three disposable razors from the clean utility room. He had broken the plastic casing off of one razor, and used that blade to cut himself. MHA took the razor blade off the floor, as well as the other two razors that the Service Recipient had taken from the clean utility room. (Justice Center Exhibit 11).

9. In the meantime, RN called the Rapid Response Team who assessed the Service Recipient and took him to the operating room where he was diagnosed with a 10 centimeter laceration on his left forearm, exposing a tendon and some muscle fibers. The wound was cleaned and closed with sutures and staples. (Justice Center Exhibits 11 and 13).

10. The clean utility room is supposed to be kept locked at all times because it contains items, such as razors, hygiene products, cleaning fluids, and oxygen tanks, that patients could use to injure themselves or others. Staff must use a key in order to enter the room. The door is equipped with a magnetic closing system that allows the door to close without being pulled shut. Once closed, the lock automatically engages. However, during the summer months, due to increased humidity, either the door or the doorjamb will swell. As a result, there are times when

[redacted]

the door sticks and does not close all the way. When that occurs, the door does not lock. (Justice Center Exhibits 4, 9 and 11; Hearing testimony of Investigator [redacted], and Hearing testimony of Subject).

11. Beginning in [redacted], repair requests were sent to the maintenance department regarding the door not closing properly. Several stop-gap measures were put into place, including lubricating the door every few days and ensuring that all staff were aware of the problem. Maintenance was concerned that if they planed the door, the opposite problem would occur when the humidity level changed in autumn and the door would not lock properly because there would be too much space between the door and the door frame. The staff was reminded to ensure that they closed the door to the clean utility room every time they exited the room. Because this was an ongoing problem, several of the staff interviewed said that it became a matter of routine to pull the door shut behind them. (Justice Center Exhibits 9 and 11).

12. The Subject testified at the hearing and during his interrogation that he would listen for the click of the lock engaging rather than pulling the door shut as he left the clean utility room. However, he also admitted that on the evening of the incident there was considerable ambient noise on the unit. (Hearing testimony of subject, Justice Center Exhibit 11).

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.

[redacted]

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 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, including Category 2 neglect, which is 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

[redacted]

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.

In this matter, the Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act(s) of neglect alleged in the substantiated report that is the subject of the proceeding and that such act(s) constitutes 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 will not be 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 does not prove 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 a prohibited act, described as "Offense 1" 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 1-9, and 12-15). The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who testified on behalf of the Justice Center at the hearing. The Subject testified in his own behalf and provided an audio CD of an interview conducted by the Justice Center Investigator [redacted] (Subject Exhibit A).

In addition to documentary evidence, the Justice Center provided an audio CD of interviews conducted by Justice Center Investigator [redacted] (Justice Center Exhibit 11) and a visual-only video of the incident, which was extremely helpful and illuminating with respect

[redacted]

to the substantiated allegations (Justice Center Exhibit 10).

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect on [redacted] when he failed to ensure that the door to the clean utility room was closed and locked. As a result of the Subject's lack of attention, the Service Recipient was able to gain access to the room, take several razors and cut himself, causing serious injuries.

The Subject had worked at [redacted] for six years when this incident occurred. As an MHA, he provided direct care to the patients on the unit and, therefore, was a custodian with a duty of care to the Service Recipient. (Social Services Law § 488(2)).

The Service Recipient had been admitted to this unit at [redacted] several times in the months leading up to this incident. On this occasion, he had been admitted since [redacted], more than three weeks prior to the incident. During the course of his stay, the Service Recipient had engaged in both self-injurious and violent behaviors. From [redacted], the Service Recipient was placed on SP status. The Service Recipient was an emotionally fragile individual with a history of opiate abuse, and would engage in behaviors designed to fulfill his cravings for pain medication. (Justice Center Exhibits 11, 12, and 14).

The Subject admitted that he knew that the door to the clean utility room was not closing properly. He testified that whenever he left the clean utility room he would listen for a click, signifying that the door was locked. However, in reviewing the video, the Subject clearly left the clean utility room and walked down the hall without pausing. If he had turned to check, he would have seen that the door had not closed all the way. The video also clearly shows that the Subject was the last person to use the clean utility room before the Service Recipient gained access to the room and the razors. (Hearing testimony of Subject, Justice Center Exhibit 10).

The Subject was also aware that the clean utility room was locked in order to prevent the

patients from accessing the supplies stored in that room. Furthermore, he was aware that disposable razors were among the supplies stored in the clean utility room. (Hearing testimony of the Subject). Therefore, the Subject had a duty to keep the clean utility room locked in order to maintain the safety of the patients under his care. When the Subject returned the vitals cart to the clean utility room, he breached his duty by not ensuring that the door was completely closed and locked.

In his defense, the Subject asserts that this does not rise to the level of neglect because he did not commit an intentional act. However, the statute does not require an element of intent. Rather, a lack of attention suffices to constitute neglect. Here, the Subject failed to pay attention to the door as it closed. On a previous occasion, when the Subject retrieved the vitals cart from the clean utility room, he pulled the door shut after him, ensuring that it was secure and locked. However, when he returned the vitals cart, he made no such effort. This lack of attention gives rise to the substantiation of neglect.

As a result of this breach of duty, the Service Recipient was able to enter the clean utility room and take three razors. He broke the plastic off of one razor and used the blade to cut his forearms. It was foreseeable that if the clean utility room was not securely locked, a patient would find something in there that could be used to cause injury. In fact, the Service Recipient required surgery to close the vein he had cut open. The wound was closed in layers, requiring sutures followed by staples. This constitutes serious endangerment and, therefore, satisfies the requirements under the statute for a Category 2 finding. (Justice Center Exhibits 11 and 13).

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.

[redacted]

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category level of abuse or neglect set forth in the substantiated report**.** As a result of the Subject's conduct in not ensuring that the clean room utility door was securely locked, the Service Recipient's health, safety and welfare were seriously endangered. As a result of the Subject's lack of attention, a serious injury did occur. Therefore, 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.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted], received and dated [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 a Category 2 act.

[redacted]

This decision is recommended by David Molik, Director, Administrative Hearings Unit.

DATED: July 11, 2016
Schenectady, New York

David Molik
Administrative Hearings Unit