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: Emily G. Hannigan, Esq.
Lippes Mathias Wexler Friedman LLP
54 State Street, Suite 1001
Albany, New York 12207

[redacted]
By: Nathaniel Charny, Esq.
Charny & Wheeler
9 West Market Street
Rhinebeck, New York 12572

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 granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of these reports shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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: April 5, 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: Elizabeth M. Devane
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
Eleanor Roosevelt State Office Building
4 Burnett Boulevard
Poughkeepsie, New York 12601
On: [redacted]

Parties: Vulnerable Persons' Central Register
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] and [redacted] (the Subjects) for neglect. The Subjects requested that the VPCR amend the report to reflect that the Subjects are not the 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 Subjects of a Service Recipient.

2. The Justice Center substantiated the report against the Subjects. 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 provide proper supervision, during which time a service recipient eloped from the unit.
>
> 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, the [redacted], located at [redacted], provides inpatient and outpatient psychiatric treatment, rehabilitation and support to adults with mental illness and is operated by the Office of

Mental Health (OMH) which is a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted])

5. Unit [redacted], located on the [redacted] floor of Building [redacted] at the [redacted], is a secure unit providing long term inpatient psychiatric care to service recipients with chronic mental illness. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted])

6. At the time of the alleged neglect, Subject [redacted] had been employed by [redacted] since 1997 and was a Registered Nurse. Subject [redacted] duties included dispensing medications, assignment of staff and care of service recipients. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibits 2, 6 and 9)

7. At the time of the alleged neglect, Subject [redacted] had been employed at [redacted] for an unspecified time as a Mental Health Therapy Aide (MHTA). Subject [redacted] duties included assisting service recipients with activities of daily life including meals and hygiene care. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibits 2a, 6 and 16)

8. At the time of the alleged neglect, the Service Recipient was 39 years old and had been a resident of [redacted] for most of the time period since [redacted] 2010. The Service Recipient had a diagnosis of schizoaffective disorder bipolar type. The Service Recipient had no history of eloping. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibits 6, 17 and 18)

9. At the time of the alleged neglect, between 8:00 p.m. and 8:30 p.m. on [redacted]

[redacted], there were 26 service recipients residing on Unit [redacted]. Four staff, including both Subjects, were working the Unit [redacted] evening shift between 3:30 p.m. and midnight. Six employees were originally on the staffing schedule for Unit [redacted] during that shift, however, due to staffing shortages at [redacted], one RN and one MHTA were floated to another floor. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibits 8, 9 and 10)

10. Unit [redacted] consisted of service recipient rooms off of two perpendicular hallways, a nurses station located where the hallways met, a small dayroom, a large dayroom and a hallway to the secure Exit/Entry door (door) which led to the elevator. All staff had keys to the door as it was self-locking to keep the floor secure. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibits 2, 6, 7, 19, 20 and 23; Subject [redacted] Exhibit A)

11. None of the service recipients, including the Service Recipient, were on any type of specialized supervision. The Service Recipient had "escorted privileges" meaning he required a staff escort when off of Unit [redacted]. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibits 6 and 7)

12. Subject [redacted] was assigned to perform the census count of the service recipients during that evening shift. Census checks were done hourly, i.e.: 6:30 p.m., 7:30 p.m. until 8:30 p.m. and, after 8:30 p.m., every half hour for the remainder of the shift. The 7:30 p.m. census check verified that all service recipients, including the Service Recipient, were present in Unit [redacted]. The next census check was due at 8:30 p.m. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice

Center Exhibits 2, 2a, 6, 9 and 10)

13. Between 7:30 p.m. and 8:30 p.m., Subject [redacted] dispensed medications to Unit [redacted] service recipients from the location of the nurse's station. [redacted] Medication Standards and Practices require assuring cleanliness, checking each patient's identification two ways, verifying the correct dosage, visually checking the medication safety and expiration date, explaining the procedure and discussing any concerns with the service recipient, checking the Medication Administration Record and medication label three times before administering the medication to each service recipient and making sure that the service recipient properly ingests the medication. Subject [redacted], as the only RN on the floor, was acting as both the Charge Nurse and the Medication Nurse that shift. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibit 2, 6, 8, 9, 15; Subject [redacted] Exhibit B)

14. At around 8:00 p.m. the Service Recipient received his medications from Subject [redacted]. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibits 2, 6, 9 and 15)

15. Also at around 8:00 p.m., Subject [redacted] began to attend to a female service recipient who had to be cleaned and changed as she was incontinent. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibits 2a, 6, 9 and 16)

16. While the Unit [redacted] door appeared locked, the lock was not functioning properly that evening. Staff was not aware that the door lock was not functioning properly at that time or at any time prior. The Service Recipient was able to open the door and leave the Unit. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing

testimony of Subject [redacted]; Justice Center Exhibits 6, 7, 11, 13, 15, 19 and 20)

17. Staff A was stationed at the front desk of the building and the Service Recipient asked Staff A to let him out of the building. Staff A then "buzzed" the Service Recipient out through each of the two secure sally port doors and then "buzzed" him out the front door of the building, as she thought he was an outpatient. Staff A did not ask to see an ID badge and did not ask if the Service Recipient was a patient or a visitor. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibit 6, 7, 11, 12 and 19)

18. When Staff B, one of the four staff on duty in Unit [redacted], left the building to go on his required dinner break, he saw the Service Recipient outside of the building. Staff B immediately returned the Service Recipient to Unit [redacted] at 8:25 p.m. The Service Recipient had been outside for a few minutes. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibit 2, 6, 7, 13, and 14)

19. Subject [redacted] immediately contacted the Nurse Administrator and on call Doctor. The incident was reported to the Justice Center. The Service Recipient did not appear affected by the event. (Hearing testimony of Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibit 6 and 7)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.

- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and 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), as:

> "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), including Category 3, which is defined as follows:

> 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 not established by a preponderance of the evidence that either Subject committed an act of neglect as 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 1-20, 22 and 23). The investigation underlying the substantiated report was conducted by OMH Clinical Risk Management Specialist/Rehabilitation Counselor [redacted]. She was the only witness who testified at the hearing on behalf of the Justice Center.

Subject [redacted] testified in her own behalf and provided a diagram of Unit [redacted] as well as the [redacted] medications standards and practice. (Subject [redacted] Exhibits A and B)

Subject [redacted] did not testify and did not present any documents.

Allegation 1 - Neglect

The Justice Center did not prove by a preponderance of the evidence that either Subject

committed neglect against the Service Recipient as alleged. In order to sustain the allegation of neglect, the Justice Center must prove that each Subject was a custodian who owed a duty to the Service Recipient, that each Subject breached her duty as a custodian by failing to provide proper supervision to the Service Recipient which allowed the Service Recipient to elope from the Unit, and that the breach committed by each either 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. (SSL § 488(1)(h))

There is no dispute that each Subject was a custodian of the Service Recipient as that term is defined in Social Services Law §488(2). At issue is whether each Subject breached her custodial duty.

The Service Recipient was a resident of the Unit for about four years and had no history of eloping. The Service Recipient was required to be escorted when off the Unit, however, while on the Unit the Service Recipient did not require any type of specialized supervision, including line of sight supervision. At the time of the incident, none of the 26 service recipients on the Unit required specialized supervision. During the time the Service Recipient eloped, Unit Census checks were required hourly. The most recent census check, conducted at 7:30 p.m., showed that the Service Recipient was present on the Unit. The next required census check was to be conducted at 8:30 p.m., after the Service Recipient was returned to the floor.

The Service Recipient eloped at some point after he received his medication from Subject [redacted] at around 8:00 p.m. and before he was returned to the Unit by Staff B at 8:25 p.m. During that time, Subject [redacted] was at the nurse's station dispensing medications to service recipients. Evidence showed that the process of dispensing medications to service recipients was detailed and that accuracy in doing so for the safety of the service recipients is crucial. Subject [redacted]

testified that the process of administering medications to each service recipient in turn took her full attention. The door from which the Service Recipient eloped was not visible from the location where the medications were dispensed at the nurse's station. During the same time, Subject [redacted] was cleaning and changing a female patient, who became incontinent, in the privacy of that service recipient's room. The door that the Service Recipient eloped from was not visible to Subject [redacted] while she was attending to the female service recipient in that service recipient's room. Both Subject [redacted] and Subject [redacted] were attending to individual service recipients, Subject [redacted] dispensing medications and Subject [redacted] cleaning an incontinent patient, performing duties that took their full attention and from vantage points where the door was not visible.

The door was self-locking to secure the Unit. Prior to the incident, there was no notification given to staff that there was any problem with the lock on the Unit door or that any special precautions needed to be taken. The day after the incident, [redacted] issued a "Nursing QA Alert" informing staff that a service recipient was able to leave through the door. As a resolution to the matter, [redacted] directed employees to ensure that the door is closed by rechecking the door handle prior to moving away from the door. There was no testimony indicating that there was any type of alarm on the door to indicate when the door was open or ajar.

Witness OMH Clinical Risk Management Specialist/Rehabilitation Counselor [redacted] agreed that, at the time of the incident, Subject [redacted] was where she was supposed to be and doing what she was supposed to do and that Subject [redacted] had done nothing wrong. She testified that she did not name either Subject specifically as responsible for the incident but found there was responsibility for the incident "as a Unit".

The Service Recipient had no specialized supervision, no history of eloping, neither

Subject had reason to think there was an issue with the lock on the door and each Subject was engaged in required specific tasks with specific service recipients. There is no evidence that either Subject breached her duty by failing to provide proper supervision to the Service Recipient.

As such, the Justice Center has not met its burden that either Subject committed neglect as alleged in Allegation 1. The substantiated report will be amended and sealed.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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

DATED: March 29, 2017
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge