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: Todd M. Sardella, Esq.

[redacted]

[redacted]

By: Nicole A. Murphy, Esq.
Fine, Olin & Anderman, LLP
39 Broadway, Suite 1910
New York, New York 10006

[redacted]

By: Alan Smikun, Esq.
Zelenitz, Shapiro & D'Agostino, PC
38-44 Queens Boulevard, 2nd Fl.
Briarwood, New York 11435

[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 individual requests of [redacted], [redacted], Carmen Rodriguez, Carol J. Simpson and Karlene Williamson that the substantiated report(s) relative to each Subject, all dated [redacted], [redacted] [redacted] be amended and sealed are denied. The Subjects have each been shown by a preponderance of the evidence to have committed neglect.

The substantiated reports are 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).

[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 21, 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: Louis P. Renzi
Administrative Law Judge

Held at: Adam Clayton Powell State Office Building
163 West 125th Street
New York, New York 10027
On: [redacted]

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subjects) for neglect. The Subjects requested that the VPCR amend the report to reflect that they are not subjects 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 [redacted] of neglect by each Subject of the service recipients.

2. After investigation of [redacted] role in the report, the Justice Center concluded that:

Allegation 1

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian and while on duty as an LPN 2, you committed neglect when you were inattentive to your shift duties by laying down on a couch in the nursing station covered in linens, and when you failed to conduct and/or document required patient verification checks.

This allegation has been SUBSTANTIATED as Category 3 neglect, pursuant to Social Services Law § 493(4)(c).

3. After investigation of [redacted] role in the report, the Justice Center concluded that:

Allegation 1

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as

a custodian and while on duty as a Mental Health Therapy Aide, you committed neglect when you were inattentive to your shift duties by sitting on the couch in the Residence's Reception area with your eyes closed.

This allegation has been SUBSTANTIATED as Category 3 neglect, pursuant to Social Services Law § 493(4)(c).

4. After investigation of [redacted] role in the report, the Justice Center concluded that:

Allegation 1

It was alleged that on [redacted], on [redacted] at the [redacted], located at [redacted], while acting as a custodian and while on duty as a Mental Health Therapy Aide, you committed neglect when you were inattentive to your shift duties by sitting on the couch in the staff office, with the lights off and with your feet elevated on a chair, covered with a stack of linens, and when you failed to complete and/or document required patient verification checks.

This allegation has been SUBSTANTIATED as Category 3 neglect, pursuant to Social Services Law § 493(4)(c).

5. After investigation of [redacted] role in the report, the Justice Center concluded that:

Allegation 1

It was alleged that on [redacted], on [redacted] at the [redacted], located at [redacted], while acting as a custodian and while on duty as a Mental Health Therapy Aide, you committed neglect when you were inattentive to your shift duties by sitting on the double couch in the staff office, with your legs on a chair, covered in linens and with the lights off, at which time you failed to respond immediately when your name was called, and when you failed to complete and/or document required patient verification checks.

This allegation has been SUBSTANTIATED as Category 3 neglect, pursuant to Social Services Law § 493(4)(c).

6. After investigation of [redacted] role in the report, the Justice Center concluded that:

Allegation 1

It was alleged that on [redacted], on Unit [redacted] at the [redacted], located at [redacted], while acting as a custodian and while on duty as a Nurse 2, Psychiatric, you committed neglect when you were inattentive to your shift duties by sitting in the treatment room with your legs extended on a chair, with the lights off, and you were talking on the telephone, and when, at approximately 4:30 A.M., patient verification checks were already documented through 5:45 A.M. for eight patients.

This allegation has been SUBSTANTIATED as Category 3 neglect, pursuant to Social Services Law § 493(4)(c).

7. An Administrative Review was conducted and as a result each substantiated report was retained.

8. The facility, [redacted] located at [redacted], is a mental health facility and is operated by the New York State Office of Mental Health (OMH), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. The [redacted] provides inpatient, outpatient and related psychiatric services. At the time of the incident complained of here, the Subjects were all employees of the [redacted] and were custodians as that term is defined in Social Services Law § 488(2). (Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Director of Nursing [redacted]; Justice Center Exhibit 7; and Subjects Exhibit A)

9. The service recipients are the residents of the short term residential care section of the [redacted] called the [redacted]. The [redacted] consists of Units [redacted] and is located on floors [redacted]. Additional service recipients are cared for in one of the [redacted]. (Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Director of Nursing [redacted]; and Justice Center Exhibits 3, 4 and 6)

10. The Subjects worked from [redacted], at 11:00 p.m. to [redacted], at 7:30 a.m.

at the [redacted]. (Hearing testimony of Subjects [redacted]; and Justice Center Exhibits 5 and 6)

11. During the 11:00 p.m to 7:30 a.m. shift, one of the enumerated duties of facility staff is to visually assess each service recipient every fifteen (15) minutes, and to make a written record of such monitoring checks by initialing the Patient Verification Checklist, to be verified at least every hour. (Hearing testimony of Director of Nursing [redacted]; Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibits 4, 6 and 7; and Subjects Exhibit A)

12. On [redacted], between approximately 4:00 a.m. and 5:30 a.m., four administrators of the facility, working in pairs, conducted "rounds", which is a supervisory check of the program. Rounds are done to observe various areas of the [redacted], to check with staff and make sure that everything is functioning as required and to see that the patients' needs are being met. Staff are aware that rounds can happen at any time. The administrators who performed the rounds on [redacted], were Nurse Administrator 2 [redacted], who was paired with Chief of Service [redacted], and Director of Nursing [redacted], who was paired with Deputy Director of Operations [redacted]. The Subjects were not advised in advance of the timing of the rounds. (Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Director of Nursing [redacted]; Justice Center Exhibits 1 and 3)

13. [redacted] had been employed at the [redacted] for approximately 23 years and was on duty during the night shift of [redacted]. [redacted] duties included assisting the Nurse Directors, Supervising Nurse Administrator 1s and Registered Nurses and various administrative duties, including making rounds. (Hearing testimony of Nurse Administrator 2 [redacted])

Subjects [redacted], LPN 2 and [redacted], Mental Health Therapy Aide (MHTA)

14. On [redacted], [redacted] and [redacted] commenced their rounds at approximately 4:00 a.m. in the lobby of the [redacted]. Finding nothing amiss, they proceeded to the eighth floor at approximately 4:15 a.m., where they discovered Subjects [redacted] and Subject [redacted] asleep in an office area, covered with linens. They also discovered that Subject [redacted] and Subject [redacted] required patient checklist had not been completed for 2:00 a.m., 3:00 a.m. and 4:00 a.m. At the same time, three service recipients were observed walking around the unit without any staff present to monitor them. Upon being awakened by the administrators, both of whom had to call them by name, in order to wake them, the Subjects offered no explanation for their behavior. Their lunch breaks had been at 2:00 a.m. and 3:30 a.m., respectively, and they were not on a scheduled break at that time. (Hearing testimony of Nurse Administrator 2 [redacted]; and Justice Center Exhibits 1, 3 and 4)

Subjects [redacted], MHTA and [redacted], MHTA

15. Continuing their rounds, [redacted] and [redacted] reached the [redacted] unit at approximately 5:40 a.m. In the office area, they discovered Subjects [redacted] and [redacted] asleep. [redacted] was sleeping at a desk with her head down on her arms. [redacted] was sitting on a couch with her legs extended on chairs, covered in linens and the lights off. The Subjects did not respond or move until the administrators called their names several times. Their lunch breaks had been at 2:00 a.m. and 2:30 a.m., respectively, and they were not on a scheduled break at that time. The Subjects had failed to complete the verification check list for 4:00 a.m. and 5:00 a.m. (Hearing testimony of Nurse Administrator 2 [redacted])

Subject [redacted], Nurse 2 (Psychiatric)

16. At approximately 4:15 a.m., [redacted] and [redacted] located Subject [redacted] in the Ward [redacted] Treatment Room, sitting in a chair, legs extended onto another chair,

lights off and speaking on the telephone. At that time, the administrators observed that the Patient Verification Check list had been pre-marked to indicate that the monitoring visits which were scheduled out through 5:45 a.m. had been made. Subject [redacted] acknowledged the error but stated that it had been done by other staff. (Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Director of Nursing [redacted]; and Justice Center Exhibits 1, 3, 4 and 6, p. 5)

ISSUES

- Whether the Subjects have been shown by a preponderance of the evidence to have committed the acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute neglect.
- Pursuant to Social Services Law § 493(4), the category of neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of 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 neglect shall be categorized into categories pursuant to SSL § 493(4), 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 Subjects committed the acts of neglect alleged in the substantiated report that is the subject of the proceeding and that such 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 acts of neglect cited in the substantiated report constitute 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 Subject [redacted], Subject [redacted], Subject [redacted], Subject [redacted] and Subject [redacted] committed category

three neglect, as described in Allegation 1 of the substantiated report.

In order to prove neglect, the Justice Center must show by a preponderance of the evidence that the Subject (i) was acting as a custodian, (ii) owed a duty of care to the service recipients, (iii) breached that duty and the breach either resulted in, or was likely to result in, physical injury or serious or protracted impairment to the physical, mental or emotional condition of any of the service recipients.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1–31[1], 33 and 34[2]). The Justice Center called three witnesses. [redacted], R.N., Director of Nursing at the [redacted], [redacted], the Director of Institutional Human Resource Management, who authored the investigative report and [redacted], R.N., Nurse Administrator, also testified on behalf of the Justice Center.

The Subjects each testified in their own behalf. Subjects Exhibit "A" was admitted on stipulation into the record. The Subjects presented no other evidence.

Admitted over the objections of counsel into the hearing record were the Notices of Discipline and Disciplinary Settlement Forms for Subjects [redacted].[3] (Justice Center Exhibits 11, 12, 16, 17, 21, 22, 26 and 27, respectively). The admission of these documents was not for any purpose related to issue preclusion or collateral estoppel, nor is any such finding made here. This recommended decision is based entirely upon the independent evidence presented at the hearing.

The hearing in this matter was conducted with five (5) Subjects, all of whom were

[1] Exhibit 2 has been redacted to avoid disclosing unnecessary personal identifying information of the Subjects, and all information, including names, relating to others who were subjects of the investigation but who are not Subjects here.
[2] There is no Exhibit 32.
[3] The Notice of Discipline regarding Subject [redacted] was admitted without objection.

represented by legal counsel and consented to having their matters consolidated into a single hearing. The allegations (and consequently the substantiation letters) were very similar for each of the Subjects; specifically, that on [redacted], while working the overnight shift at the Bronx [redacted], each Subject was inattentive to his or her shift duties, having been found during administrative rounds to be either asleep or in a resting/relaxing position during working hours, without authorization for such conduct. Additionally except for Subject [redacted], all of the Subjects were alleged by the Justice Center to have failed to conduct and/or document required "patient verification checks" during the shift, thereby indicating a failure to properly monitor the service recipients. The record is not clear why a similar allegation was not made against Subject [redacted], as his job title of Mental Health Therapy Aide (MHTA) supports the conclusion that he shares the responsibility with his co-workers to monitor the Service recipients. Nevertheless, as a MHTA he is a direct care staff member, and his primary job function is to participate in the monitoring and daily care of the service recipients in his charge. Subject [redacted] could not perform that function from a resting position, feet up, eyes closed and covered in linens in a darkened room. Whether he was actually asleep, which he denied during his testimony, is immaterial.

In short, the Subjects were found to be inattentive and to have neglected their duties. There is no indication that any of these employees were on scheduled breaks when found. Sleeping while on the job is not permitted staff behavior. During the rounds, service recipients were found awake and unsupervised in [redacted]. (Hearing testimony of Nurse Administrator 2 [redacted]; and Justice Center Exhibits 1, 3, 4 and 6)

Special attention is owed to the allegation against [redacted], Nurse 2 (Psych). Subject [redacted], a 16-year veteran of the [redacted], was found sitting in the Ward [redacted] Treatment Room with her legs extended on another chair and talking on the phone. During her testimony,

she stated that she was talking on a facility phone, as there was no cell service available. She also claimed, for the first time, to have been on a break at the time she was found by [redacted] and [redacted].

During cross-examination by Justice Center counsel, Subject [redacted] admitted that while being questioned during the original investigation of the matter, she never claimed to have been on break. (Hearing testimony of Subject [redacted]; and Justice Center Exhibit 30) Consequently, it is reasonable to conclude that her testimony was self-serving, at least in part. Notwithstanding, it was Subject [redacted], whose Patient Verification Check list had been pre-marked as completed for monitoring visits scheduled out to 5:45 a.m. Subject [redacted] acknowledged at the time that this had been done incorrectly, but claimed that it was done by someone other than herself.

Notwithstanding this evidence, Subject [redacted] duties as a nurse also included supervising MHTA staff and reviewing and approving their work. The Subject is responsible for ensuring that 15 minute Patient Verification Checks are completed and documented at least hourly according to the 2007 [redacted] policy that was in place at the time of the neglect. (Justice Center Exhibit 7) Although the policy was amended after its implementation in 2007, none of the changes materially alter the frequency of patient monitoring visits, or the recordkeeping thereof, during the night shift. The policy still requires monitoring service recipients every 15 minutes after 8:00 p.m. (Subjects Exhibit A) The purpose of Patient Verification Checks is to assure that all service recipients are accounted for and that their locations are identified at regular intervals. (Hearing testimony of Nurse Administrator 2 [redacted]; Justice Center Exhibits 3, 6, p. 5 and 7; and Subjects Exhibit A)

As a nurse and supervisor, Subject [redacted] is responsible for such errors of her subordinates. (Hearing testimony of Subject [redacted]; Hearing testimony of Director of

Nursing [redacted]; Justice Center Exhibit 4, 6 and 7; and Subjects Exhibit A)

The Subjects' failure to properly monitor the service recipients was likely to result in physical injury or serious or protracted impairment to the physical, mental or emotional condition of the service recipients. With respect the 15-minute visual monitoring requirement, the [redacted] policy states:

> Q15 MINUTE OBSERVATION
>
> Certain patients may require a less restrictive observation status but are still in need of periodic assessment. These patients may be a potential risk or harm to property, self or others, may be an elopement risk, or may have the potential for rapid medical deterioration. In this group of patients, however, the likelihood of violence or self destructive acts is not immediate. Rather, based on the previous record and the present condition of the patient, the patient is clinically assessed to be manageable on an every 15 minute basis, i.e., the patient is unlikely to escalate to immediate dangerousness in less than 15 minutes and thus the 15 minute interval assessment allows adequate time for intervention, if necessary. Q15 Minute Observation requires that a staff member make at least visual contact and assess a patient every 15 minutes.
>
> (Justice Center Exhibit 7, pp. 4-5)

The Subjects breached their duty to the service recipients by their lack of attention in failing to ensure patient verification checks were performed and properly documented. This is the most important part of their job, according to the testimony of the Director of Nursing, [redacted]. Their breaches, individually and collectively, was likely to have resulted in physical injury or serious or protracted impairment to the physical, mental or emotional condition of any one of the service recipients. The record reflects that a number of service recipients were observed moving about unsupervised at various locations throughout the [redacted]. (Hearing testimony of Director of Nursing [redacted])

Subject [redacted] also argued that the [redacted] was understaffed. The evidence does not support the contention that the staffing was low during the shift. Every position required to be

filled was filled. (Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Subject [redacted]; Justice Center Exhibits 5 and 6) However this argument has no merit in regard to the issue of her lack of attention.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subjects committed the neglect alleged. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report**.** Category 3 is described in SSL §493(4)(c) as abuse or neglect that is not otherwise described or defined in SSL §493 as either category 1 or 2. 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 individual requests of [redacted], [redacted], Carmen Rodriguez, Carol J. Simpson and Karlene Williamson that the substantiated report(s) relative to each Subject, all dated [redacted], [redacted] [redacted] be amended and sealed are denied. The Subjects have each been shown by a preponderance of the evidence to have committed neglect.

The substantiated reports are properly categorized as a Category 3 act.

This decision is recommended by Louis P. Renzi, Administrative Hearings Unit.

DATED: July 11, 2016
Schenectady, New York

Louis P. Renzi, ALJ