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]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

This decision is ordered by Elizabeth M. Devane, ALJ, Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: **October 15, 2018**
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Emily Hannigan, Esq.

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: Susanna Requets
Administrative Law Judge

Held at: Administrative Hearings Unit
New York State Justice Center for the Protection of People with Special Needs
9 Bond Street – 3rd Floor
Brooklyn, New York 11201
On: [redacted]

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

[redacted]
By: Emily G. Hannigan, Esq.
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54 State Street, Suite 1001
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted][1] (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], of neglect by the Subject of a Service Recipient.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Allegation 1

> It was alleged that on [redacted], at the [redacted], located at [redacted], while a custodian, you committed neglect when you drew blood from a service recipient while he was standing.
>
> 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, located at [redacted], provides intermediate level inpatient psychiatric services, and is operated by the New York State Office of

[1] The Subject's complete name is [redacted].

Mental Health (OMH), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Justice Center Investigator [redacted] [Investigator [redacted]]; Justice Center Exhibit 6)

5. At the time of the alleged neglect, the Subject was employed by the facility as a Registered Nurse (RN) for seventeen years. The Subject worked the overnight shift in the [redacted] Ward Unit [redacted] (Unit [redacted]) of the facility. She was responsible to communicate with the evening nurse concerning the patients and any incidents that may have occurred during the prior shift, account for the patients and narcotics, generate assignments for staff, review doctor orders, complete medical paperwork, and cover for a Mental Health Therapy Aide (MHTA) while the MHTA took a break. (Hearing testimony of the Subject; Justice Center Exhibits 6 and 11) The Subject was a custodian as that term is defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was 51 years old, and had been a resident of the facility for approximately four years. The Service Recipient was an adult male with relevant diagnoses of schizoaffective disorder (bipolar type), depression and alcohol abuse. (Justice Center Exhibits 6 and 15)

7. Unit [redacted] was comprised of patient rooms, a nursing station and a dining room. The nursing station had a medication counter, that measured about fifteen feet to eighteen feet long, and four feet high. A rolling chair was near the nursing station for the exclusive use of the MHTA. The nursing station was lit with fluorescent lighting. Fifteen feet from the nursing station was a dining room with five to six round tables, each with about four to five connected chairs. The dining room had dim lighting. Unit [redacted] did not have a phlebotomy chair before or after the alleged incident. (Hearing testimonies of the Subject, MHTA 1[2], and retired Nurse Administrator (NA 1[3]))

[2] MHTA 1 was [redacted].
[3] NA 1 was retired Nurse Administrator [redacted].

8. A treatment room was located down the hall and outside of the Unit [redacted]. At the time of the alleged neglect, there was a stretcher, medical code cart, oxygen tank, sink, scale and humidifier in the treatment room. (Hearing testimony of the Subject)

9. On [redacted], the Subject, MHTA 1 and MHTA 2[4] worked the overnight shift. The Subject worked from 11:30 p.m. to 8:00 a.m., MHTA 1 worked from 12:00 a.m. to 8:00 a.m. and MHTA 2 worked from 11:30 p.m. to 7:00 a.m. (Hearing testimonies of the Subject, MHTA 1 and MHTA 2)

10. The Subject was assigned to perform venipuncture for four patients, which was usually performed at 6:00 a.m. The Service Recipient was not scheduled for venipuncture on [redacted]. He refused to comply with his biannual blood work for at least two days prior to [redacted]. (Hearing testimonies of the Subject and MHTA 2; Justice Center Exhibits 12 and 20: audio recording of Justice Center interview of the Service Recipient)

11. At approximately 7:00 a.m., the Service Recipient approached the medication counter, made eye contact, smiled at the Subject, and extended and flexed his arm on the medical counter. The Subject drew blood from the Service Recipient while he stood at the medication counter. (Hearing testimonies of the Subject, MHTA 1 and MHTA 2; Justice Center Exhibits 11 and 20: audio recording of Justice Center interrogation of the Subject and interviews of MHTA 1 and MHTA 2)

12. The Service Recipient's hand started slipping, he became light headed and his chin collided with the medication counter. The Subject screamed for help and grabbed the Service Recipient's arm. MHTA 1 heard the Subject scream and grabbed the Service Recipient before he fell on the ground. MHTA 1 and MHTA 2 escorted the Service Recipient to the dining room to

[4] MHTA 2 was [redacted].

sit down and the Subject gave him water. (Justice Center Exhibit 20: audio recording of Justice Center interrogation of the Subject and interviews of MHTA 1 and MHTA 2)

13. The Service Recipient's chin bled profusely and he sustained a deep laceration on his chin. The Subject contacted the night Nurse Administrator and Chief of Staff. (Justice Center Exhibits 7, 20: audio recording of Justice Center interrogation of the Subject and interviews of the Service Recipient and MHTA 1)

14. The Service Recipient received four sutures, to close the laceration on his chin, in the [redacted] emergency room. Upon the Service Recipient's return to Unit [redacted], the sutures opened and he received follow-up medical treatment consisting of medical grade glue and steri-strips. (Justice Center Exhibits 7, 9, 10 and 13)

15. The facility venipuncture policy states that a nurse should "[n]ever attempt to draw blood with the patient standing." (Justice Center Exhibits 14 and 20: audio recording of Justice Center interview of NA 2[5])

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute 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 neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice

[5] NA 2 is Nurse Administrator 2 [redacted].

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), as follows:

> "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)(c), 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 established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 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 through 7, 9 through 19 and 22) The Justice Center also presented audio recordings of the Justice Center Investigator's interview of witnesses and interrogation of the Subject. (Justice Center Exhibit 20) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who testified at the hearing on behalf of the Justice Center. MHTA 1 also testified on behalf of the Justice Center.

The Subject testified in her own behalf. MHTA 2 and NA 1 testified on the Subject's behalf.

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subject's action, inaction or lack of attention breached a duty that 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 Recipients. (SSL § 488(1)(h))

The facts relevant to the issues in this hearing are mostly undisputed. The Subject drew blood from the Service Recipient while the Service Recipient stood at the medication counter. The Subject was aware that the facility venipuncture policy prohibited patients from standing while their blood was drawn. (Hearing testimony of the Subject; Justice Center Exhibit 20: audio recording of Justice Center interrogation of the Subject)

The Subject argued that despite the policy, the facility practice for decades has been to draw blood from patients at the medication counter unless the patient could not stand or had an unsteady gait. The Subject worked with two MHTA's for seventeen years where she was the only staff during her overnight shifts that was qualified to perform venipuncture. The Subject routinely used her nursing judgment to assess whether the patient was physically able to stand or sit. (Hearing testimonies of the Subject, NA 1, MHTA 1 and MHTA 2; Justice Center Exhibits 11 and 20: audio recording of Justice Center interrogation of the Subject)

The Subject also argued that Unit [redacted] did not have an adequate space for taking patients' blood and that the medication counter was the most suitable location because of the fluorescent lighting and the height of the counter. The Subject claimed that the dining room was not suitable for drawing blood because of the lack of lighting and uncomfortable chairs. The Subject also claimed that patients were at risk for possible infections in the dining room because breakfast, lunch and dinner was eaten there. The Subject claimed that the treatment room was not suitable for drawing blood because it was necessary that one MHTA be with her while drawing blood. If the Subject and one MHTA left Unit [redacted] to go to the treatment room, only one MHTA would remain in Unit [redacted]. However, two staff members were always required to be present in Unit [redacted]. (Hearing testimony of the Subject; Justice Center Exhibit 20: audio recording of Justice Center interrogation

of the Subject)

The Subject's arguments are not persuasive because the Subject's practice for twenty years does not establish an approved facility custom and practice. The facility policy is unambiguous, unequivocal, and only subject to one interpretation – "Never attempt to draw blood with the patient standing." Despite the facility policy prohibiting patients from standing while giving blood, the Subject subjectively assessed whether the Service Recipient could stand or sit. The Subject had a duty to ensure that the Service Recipient did not stand while giving blood. A policy not followed by staff does not negate the Subject's duty to comply with the policy. The Subject, therefore, breached her duty when she drew blood from the Service Recipient while he was standing. (Hearing testimonies of the Subject, MHTA 1, MHTA 2; Justice Center Exhibits 14 and 20: audio recording of Justice Center interrogation of the Subject and interview of NA 2)

The record reflects that it was not impossible to comply with the policy because the dining room was available to draw blood. The dining room was only fifteen feet from the nurse's station, and had tables and chairs where the patient could sit while blood was drawn. An MHTA was needed to secure the patient and clear the area regardless of the location where the blood was drawn, whether it was in the dining room or the medication counter. Since at least two staff were required to be present in Unit [redacted] at all times, an MHTA could assist a nurse with the venipuncture in the dining room without leaving Unit [redacted] below the minimum required staff. Furthermore, breakfast was not distributed until 7:50 or 8:00 a.m. in the dining room, allowing sufficient time to draw blood at 6:00 a.m. and clean the area. (Hearing testimonies of the Subject and MHTA 2)

Despite the Subject's concerns about the suitability of using the dining room to draw patients' blood, the record reflects that the Chief of Staff directed the nurses to draw blood in the dining room after the incident. The facility did not order a phlebotomy chair for Unit [redacted], the facility

did not add additional chairs or tables to the dining room, and the facility did not add or change the lighting in the dining room. (Hearing testimony of the Subject; Justice Center Exhibit 20: audio recording of interview of MHTA 2)

The Subject's breach of her duties caused physical injury to the Service Recipient which required two emergency room visits and four sutures. The purpose of the policy was to prevent patient discomfort and to prevent the patient from fainting. The Service Recipient fainted, collided with the medication counter and injured his chin while standing and having his blood drawn. (Justice Center Exhibit 20: audio recording of Justice Center interview of NA 2)

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 and sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report.

Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act. Substantiated Category 3 findings of neglect will not result in the Subject's name 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 SSL § 496 (2). The report will be sealed after five years.

DECISION: 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 3 act.

This decision is recommended by Susanna Requets, Administrative Hearings Unit.

DATED: October 1, 2018
Brooklyn, New York

Susanna Requets, ALJ