

**STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE
WITH SPECIAL NEEDS**

In the Matter of the Appeal of

██████████

Pursuant to § 494 of the Social Services Law

**FINAL
DETERMINATION
AND ORDER
AFTER HEARING**

Adjud. Case #:

██████████

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 Sardella, Esq.

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██████████
██████████

By: Nathaniel K. Charny, Esq.
Charny & Associates
9 West Market St.
Rhinebeck, New York 12572

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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 ██████████ that the substantiated report dated ██████████, ██████████, ██████████ be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated report is 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).

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: May 20, 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

██████████

Pursuant to § 494 of the Social Services Law

**RECOMMENDED
DECISION
AFTER
HEARING**

Adjud. Case #:

██████████

Before:

Louis P. Renzi
Administrative Law Judge

Held at:

Adam Clayton Powell State Office Building
163 West 123th Street
New York, New York 10027
On: ██████████

Parties:

Vulnerable Persons' Central Register
New York State Justice Center for the Protection
of People with Special Needs
161 Delaware Avenue
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By: Nathaniel K. Charny, Esq.
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9 West Market St.
Rhinebeck, New York 12572

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:

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 maintain proper supervision (1:1 arms length) of a service recipient by allowing him to walk away from you, out of arms reach.

This allegation has been SUBSTANTIATED as a Category 3 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, [REDACTED], located at [REDACTED] provides both outpatient and inpatient services to those with serious mental illness 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.
(Hearing Testimony of Investigator [REDACTED])

5. At the time of the alleged neglect, the Subject had been employed by the [REDACTED] since [REDACTED], 2007 as a Mental Health Therapy Aide (MHTA). MHTAs are responsible for assisting service recipients with activities of daily life. The Subject was a custodian as that term is defined in Social Services Law § 488(2). (Hearing testimony of Subject)

6. At the time of the alleged neglect, the Service Recipient was 61 years old and had been a resident in the secure area of [REDACTED] for an unspecified period. He was ambulatory, verbal and intelligent. He was diagnosed as psychotic. (Hearing testimony of Investigator [REDACTED], [REDACTED], Hearing testimony of Subject, Justice Center Exhibit 7)

7. Pursuant to Physicians Orders on [REDACTED], the Service Recipient was ordered to be monitored on a Level I basis due to his threats to burn down the hospital and for suspicion of fire setting. The order was necessary to maintain safety. In addition to Level I monitoring, the Service Recipient had to be observed in the bathroom and searched for contraband. (Justice Center Exhibits 6 and 7)

8. Pursuant to [REDACTED] policy, the category “Level I – 1:1 Constant Observation, Unobstructed View” mandates constant visual contact by one staff assigned to one service recipient and monitoring must be close enough to intervene rapidly if needed. Specifically, staff watching must remain within “six feet” of the service recipient. (Hearing testimony of Investigator [REDACTED], Justice Center Exhibits 10 and 10A)

9. At the time of alleged neglect the Subject was working a shift from 11:45 p.m. on [REDACTED] until 7:45 a.m. [REDACTED]. The Subject was assigned to supervise the

Service Recipient on a Level I basis from 11:45 p.m. until 3:30 a.m. for that shift. (Justice Center Exhibits 6 and 9).

10. At approximately 2:45 a.m. on [REDACTED], the Nurse Administrator 1 (NA1) was the supervisor on duty and was doing rounds. She walked onto the unit where the Service Recipient resided and saw the Service Recipient standing alone at the Nursing Station. The NA1 asked the Registered Nurse (RN) who was in charge of the Service Recipient and discovered it was the Subject's assignment. The Subject was observed in the hallway by the Service Recipient's room, approximately 150 feet away from the Nursing Station and the Service Recipient's actual location. (Hearing testimony of Investigator [REDACTED], Justice Center Exhibits 3, 5 and 8)

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/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 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) 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(4), including Category 3, which is defined as follows:

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

If the Justice Center proves the alleged abuse and/or 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 abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or 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 neglect. The Subject failed to maintain a proper level of supervision of the Service Recipient, as the Subject was further than six feet away from the Service Recipient, in violation of Orders specific to the Service Recipient and in violation of [REDACTED] Policy.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1 – 10A) The investigation underlying the substantiated report was conducted by Investigator [REDACTED]. Since [REDACTED] 2015, [REDACTED] has been an Internal Investigator for the NYS Justice Center, but at the time of the incident she was an Investigator for the Office of Mental Health at the [REDACTED], where she had worked for 16 years. She was the only witness who testified at the hearing in behalf of the Justice Center.

The Subject testified in his own behalf and did not present any documents.

At the time of the neglect, approximately 2:45 a.m. on [REDACTED], the Subject was the custodian of the Service Recipient who was to be monitored on a Level I basis as required by Physicians Orders. Pursuant to [REDACTED] Nursing Policy and Procedure there was to be no more than six feet between the Subject and the Service Recipient. The Subject allowed the Service Recipient to walk away from him, putting approximately 150 feet between them. (Hearing testimony of Investigator [REDACTED], Justice Center Exhibits 3, 5, 6, 7, 8, 9, 10 and

10A)

The NA1 was the overall supervisor of the building and doing rounds when she saw the Service Recipient standing alone at the Nursing Station and at the same time saw the Subject down a long hallway by the Service Recipient's room, approximately 150 feet away. The RN on duty in charge of the ward also saw the Service Recipient by himself at the Nursing Station and the Subject down the hallway by the Service Recipient's room. The distance between the Service Recipient and the Subject was in excess of six feet. The testimony of the NA1 and RN are credited. Both witnesses said that when the Subject was asked whether he realized the Service Recipient left his care, the Subject said he did not realize and that he was sorry. By his own statement the Subject admitted he was not paying full attention to the Service Recipient. The Subject breached his duty to maintain 1:1 supervision and thus he was in violation of the Physicians Orders as well as the [REDACTED] Nursing Policy and Procedure. (Hearing testimony of Investigator [REDACTED], Justice Center Exhibits 3, 5, 7 and 8)

The Subject argued that he thought as long as he had an unobstructed view of the Service Recipient, that was sufficient supervision. He said he could see the Service Recipient down the hall. The Subject also argued that [REDACTED] Nursing Policy and Procedure, which includes a description of Level I supervision, applies to nurses and that since he was a MHTA, the six feet rule did not apply to him. The Subject's arguments are without merit. The Subject acknowledged that after the incident he was reeducated on Level I supervision standards. Investigator [REDACTED] testified that [REDACTED] Nursing Policy and Procedure does apply to MHTA's and that the Subject was required to follow this Policy. The fact that the Subject was again educated on the Policy acknowledges both that he is subject to the Policy and that he should have been aware of it in the first place. (Hearing testimony of Subject, Hearing testimony

of Investigator ██████████)

The Subject argued that he and the NA1 did not get along with one another and the NA1 harassed him. At the hearing, the Subject posited that the basis for the discord between them was the NA1's unrequited romantic notions toward him. The NA1 had made a previous allegation that the Subject was sleeping on duty. ██████████ investigated and unsubstantiated that claim. When investigating the instant matter, ██████████ was aware of the history between the parties and while having that awareness, found evidence sufficient to substantiate this particular matter. There is no indication that the NA1 fabricated the story. (Hearing testimony of Subject, Hearing testimony of Investigator ██████████)

The Subject never denied being more than six feet from the Service Recipient. In fact, at one point the Subject testified that he was only ten feet from the Service Recipient. That is a slippery slope that we decline to negotiate, particularly since the credible evidence on this record proved that, for some period of time observed by two witnesses, the Subject and Service Recipient were approximately one hundred fifty (150) feet apart. Thus, a ten-foot separation at a different point in time – even if on the same shift - is irrelevant here. The Orders and Policy specifically state six feet for safety reasons. Any distance between the parties in excess of six feet is a breach of duty owed to the Service Recipient. (Hearing testimony of Subject)

The Subject's breach of his duty likely could have resulted in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The Service Recipient had made continuous threats to burn down the hospital and was suspected of starting fires. For the safety of the Service Recipient as well as the safety of the other service recipients and staff, the Subject had to be within six feet of the Service Recipient. The Service Recipient could have found materials in the hall or Nursing Station to start a fire later. The

Service Recipient could have started a fire in the hall or run to the bathroom to do so. Any number of instances could have likely occurred from the breach. The reason for the six foot distance was to avoid any such incidents. Had an incident occurred, the Subject would have been too far away to intervene.

The Subject was the Service Recipients custodian and under Physicians Orders and Protocol was required to be within 6 feet of the Service Recipient at all times. The Subject's breach of his duty by allowing excessive space between himself and the Service Recipient likely could have resulted in a fire and/or serious injuries.

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.

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. 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 request of that the substantiated report dated , be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and/or neglect.

The substantiated report is properly categorized, as a Category 3 act.

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

DATED: May 10, 2016
Schenectady, New York



Louis P. Renzi, ALJ