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]

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 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.

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 4, 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
161 Delaware Avenue
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By: Todd M. Sardella, Esq.

[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.

2. The Justice Center substantiated the report against the Subject. 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 Registered Nurse, you committed neglect when you were inattentive to your shift duties when you were sitting in the reception area rather than monitoring the residents, 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. An Administrative Review was conducted and as a result the substantiated report was retained.

4. 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.

5. At the time of the alleged neglect, the Subject had been employed by the [redacted] since 2000 and was working as a Registered Nurse. (Hearing testimony of Subject; Justice Center Exhibit 10)

6. 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]. (Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Subject; Justice Center Exhibits 3 and 6)

7. On [redacted], the Subject worked the 11:00 p.m. to 7:30 a.m. shift at the [redacted]. The Subject was assigned as the On Duty Registered Nurse night supervisor for the [redacted]. As a supervisor, the Subject was responsible for all of the units and floors in the [redacted]. Her assigned base location was the Crisis Ward on Unit [redacted]. An additional Registered Nurse was working at that location as well. While that was her base, the Subject could be at any location within the [redacted] as she was responsible for that entire area. She was responsible for ensuring that the staff she supervised properly performed their duties. (Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Subject; Hearing testimony of [redacted]; Justice Center Exhibit 6)

8. The Subject is responsible to ensure that hourly Patient Verification Checks are completed. Patient Verification Checks are done to assure that all service recipients are accounted for and their location identified at regular intervals. (Hearing testimony of Nurse Administrator 2 [redacted]; Justice Center Exhibits 3, 6 and 10)

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

10. During the 11:00 p.m. to 7:30 a.m. shift on [redacted], [redacted] and [redacted] paired together to do rounds. They performed rounds on the [redacted], the area where the Subject was assigned as the Supervisor. The Subject and staff were not advised in advance of the rounds. (Hearing testimony of Nurse Administrator 2 [redacted]; Justice Center Exhibit 3)

11. During these rounds, employees under the Subject's supervision were found to be inattentive and to have neglected their duties. One employee was found in an office sitting on a couch with his eyes closed. Another employee was discovered on a couch covered in linens and her name had to be called several times to rouse her. This employee also failed to initial Patient Verification Check forms for 2:00 a.m., 3:00 a.m. and 4:00 a.m. of the shift. Another employee was found in a treatment room sitting with his eyes closed and shoes off. He had to be addressed by name a number of times to be roused. This employee did not complete the required Patient Verification Check forms for 3:00 a.m. or 4:00 a.m. of that shift as required and the residents were not monitored for their location and status. There is no indication that any of these employees were on scheduled breaks when found. Sleeping while on the job is not acceptable.

During the rounds service recipients were found awake and unsupervised in various areas of the [redacted] including the lobby, dayroom and hallway/reception area. (Hearing testimony of Nurse Administrator 2 [redacted]; Justice Center Exhibits 1, 3, 4 and 6)

12. At approximately 4:40 a.m. during the shift, [redacted] and [redacted] observed the Subject and a number of staff gathered at one area. Such a gathering was unusual, absent a meeting, as staff were to be located throughout the [redacted] to properly monitor the residents. (Hearing testimony of Nurse Administrator 2 [redacted]; Justice Center Exhibits 3, 4 and 6)

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 abuse and/or 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:

> (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 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

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 one of the service recipients.

The Justice Center has established by a preponderance of the evidence that the Subject committed neglect, 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 - 10). The Justice Center presented two witnesses. [redacted], a Registered Nurse and a Nurse Administrator 2, who was on duty at the [redacted] during the evening shift of [redacted] testified. [redacted], the [redacted] at the [redacted], who authored the investigative report, also testified.

The Subject testified in her own behalf and presented no other documents or evidence.

The Justice Center proved by a preponderance of the evidence that on [redacted], on Unit [redacted] at the [redacted], that the Subject, while acting as a custodian and working as the On Duty Registered Nurse night supervisor, committed neglect. Specifically, the Subject failed to perform her duties and supervise her staff which resulted in the failure to properly monitor the service recipients on the [redacted]. The [redacted] provides psychiatric services to these service recipients. Failure to properly monitor the service recipients is likely to result in physical injury or serious or protracted impairment to the physical, mental or emotional condition of any one of the service recipients.

The Subject was the Registered Nurse Supervisor on duty. The [redacted] consisted of Units [redacted] which were located on floors [redacted]. As the Supervisor of the [redacted], the Subject was required to walk through all of the Units on each of those floors and make sure work was properly being performed by the employees and that the patients were accounted for and safe throughout her entire assigned area. She was supervising 9 employees. Several of those employees were found upon random rounds to be sleeping or, at least, extraordinarily inattentive to their duties. Employees in the [redacted] are required to monitor the residents. Sleeping while on the job is not acceptable. Nurse Administrator 2 [redacted] testified that patient verification checks are the most important part of the shift. The employees under the Subject's supervision did not complete or sign off on hourly patient verifications as required. The time to complete the verifications had passed and the checklist could not be accurately completed after the fact. (Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Subject; Hearing testimony of [redacted]; Justice Center Exhibits 1, 3, 4 and 6)

The Subject breached her duty to the service recipients by her lack of attention in failing to properly supervise her staff and by her inaction in failing to ensure patient verification checks were completed. Her breach very likely could have resulted in physical injury or serious or protracted impairment to the physical, mental or emotional condition of any one of the service recipients. A number of service recipients were in fact observed unsupervised at various locations throughout the [redacted].

In her own defense, the Subject testified that she was assigned to a particular ward that evening. Since she was assigned to a ward, the Subject argued that she could not go to other areas of the [redacted] to supervise matters. The Subject's argument holds no weight. The Subject

knew she was the supervisor of the [redacted] during the shift in question. When a supervisor is assigned to a ward, the ward is considered merely their base location. The supervisor is not required to stay in that one area but is in fact expected to move around the entire area assigned them, in this case the entire [redacted]. Additionally, any additional duties aside from supervision do not lessen the responsibilities of the supervisor to supervise the entire area. The Subject did not properly monitor the [redacted]. (Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Subject; Justice Center Exhibits 3, 6, 9 and 10)

The Subject also argued that the [redacted] was understaffed, which affected her performance of duties. The evidence does not support the contention that the staffing was low during the shift. Every position required to be filled was filled. Another Registered Nurse was located at the Crisis Unit which [redacted] indicated was in fact an additional resource for the Subject. (Hearing testimony of Nurse Administrator 2 [redacted]; Hearing testimony of Subject; Justice Center Exhibits 3, 6, 9 and 10)

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**.** 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. Category 3 implies some measure of endangerment of the health, safety or welfare of service recipients, but the level of seriousness of that endangerment is somewhat less than “serious endangerment”, the standard for a category 2

finding. Here, based upon the totality of the circumstances as supported by this record, it is determined that the substantiated report is properly categorized as a Category 3 violation.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [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 Louis P. Renzi, Administrative Hearings Unit.

DATED: April 29, 2016
Schenectady, New York

Louis P. Renzi, ALJ