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: Theresa Wells, Esq.

[redacted]

By: Constance R. Brown, Esq.
CSEA, Inc.
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224

[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] of neglect by the Subject of Service Recipients 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: October 28, 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

Adjudication Case #: [redacted]

Before: Jean T. Carney
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
401 State Street
Schenectady, New York 12305
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 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 Service Recipients.

2. The Justice Center's Report of Substantiated Finding concluded that:

Allegation 1

> It was alleged that on [redacted], at the [redacted], Crisis Inpatient Unit, located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision to the six service recipients on the unit, when you fell asleep and/or were less than alert for periods of time during your overnight awake shift.
>
> 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 psychiatric in-patient mental health treatment facility for individuals with serious and persistent mental illnesses. The facility is operated by the New York State Office of Mental Health (OMH), which is a provider agency that is subject to the

[redacted]

jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject had been employed at [redacted] since [redacted] as a Mental Health Therapy Aide (MHTA). (Hearing testimony of Subject)

6. On [redacted], the Subject was assigned to the Crisis Inpatient Unit (CIP) and worked his regular overnight shift [redacted] Although the Subject was usually assigned to Unit [redacted] all staff were cross-trained, affording them the ability to float to other units when needed. There were seven service recipients in CIP that night, none of which required special monitoring at the time of the incident. The Subject and the supervising nurse were the only two staff members assigned to the unit during that shift. Service recipients are admitted temporarily to the CIP from the crisis emergency room. Once they are stabilized, they are transferred to another unit. (Hearing testimony of Subject; Hearing testimony of Clinical Risk Manager [redacted]; Justice Center Exhibit 6)

7. At the time of the alleged incident, [redacted] policy specifically stated that all staff were expected to remain awake and alert during their assigned shifts and anything less would be a clear failure to perform their required duties. This attentiveness requirement was implemented to ensure the safety of the facility's vulnerable population of service recipients at all times, especially in light of the CIP unit's emergency triage status. (Hearing testimony of Clinical Risk Manager [redacted]; Justice Center Exhibit 6 and 13)

8. In addition to staying awake and alert, the Subject's duties included completing rounds every 30 minutes to assess and note the location and status of each service recipient in the unit. The Subject was further responsible for completing a number of documents in preparation for the morning shift, as well as attending to service recipient's needs throughout the night. During the course of the shift, the Supervising Nurse observed the Subject either dozing off or completely asleep on a number of occasions. The nurse called his name a few times and encouraged the

[redacted]

Subject to get up and walk around to help keep alert. At the end of the shift, the supervising nurse notified the Facility Supervisor of the Subject's inability to stay alert and awake, and of the difficulties he encountered in completing routine tasks during the overnight shift. (Hearing Testimony of Risk Manager [redacted] Hearing testimony of Subject; Justice Center Exhibits 6, 7, 8 and 12)

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 allegation constitutes 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 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):

> "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

[redacted]

> 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

The Justice Center has established by a preponderance of the evidence that the Subject committed the act described as Allegation 1 in the substantiated report.

In support of its substantiated findings, the Justice Center presented documents obtained during the investigation. (Justice Center Exhibits 1-15) The investigation underlying the

[redacted]

substantiated report was conducted by [redacted] Risk Manager [redacted] who testified on behalf of the Justice Center. In addition to the documentary evidence, the Justice Center provided visual-only videos of the overnight shift, which was extremely helpful and illuminating with respect to the substantiated allegations. (Justice Center Exhibit 16) An audio recording of Risk Manager [redacted] interrogation of the Subject was also provided. (ALJ Exhibit 1)

The Subject testified at the hearing in his own behalf and offered one document, which was admitted into evidence. (Subject Exhibit A)

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect by his failure to provide proper supervision to the services recipients on the unit. Specifically, the Subject's inability to stay awake and alert during the overnight awake shift was a breach of facility policy and was likely to have resulted in physical injury or serious protracted impairment of the service recipients' physical, mental or emotional condition.

There is no dispute that the Subject was acting as a custodian for the CIP service recipients as defined by law, nor is it disputed that the Subject was fully aware of his required duties. The Subject had been employed in the mental health field by New York State for close to three decades, with his employment beginning at [redacted] in 2012. Admittedly, as an MHTA on the overnight shift, the Subject was responsible for monitoring and supervising the service recipients on the unit including completing rounds every 30 minutes, taking vital signs, escorting patients as needed, completing necessary documents, and providing an overall safe and therapeutic environment. The Subject testified to these required duties without question. The Subject further verbalized a clear and coherent knowledge of facility policy regarding staying awake and alert at all times during overnight shifts. The need for vigilant supervision during the overnight shift was crucial due to the significant potential for danger given the unpredictable tendencies of the unit's residents and given the fact that there were only two staff members on shift that night. (Hearing testimony of

[redacted]

Subject; Justice Center Exhibits 6, 12, 13, 15; Subject Exhibit A and ALJ Exhibit 1).

As evidence, the Justice Center proffered the written statement of Nurse [redacted] detailing the night's events regarding the Subject's marked level of inattentiveness. Nurse [redacted] specifically described each task that the Subject failed to perform and delineated those that required her correction. Nurse [redacted] stated that she had to re-write a number of documents and how she chastised the Subject at one point for doodling on facility paperwork. In her statement, as well as in her interview with Risk Manager [redacted], Nurse [redacted] characterized the Subject as visibly exhausted and noted a number of times where she found him asleep or less than alert. (Justice Center Exhibits 6, 7, 8 and 16)

Video of the overnight shift provides clear evidence of the Subject's failure to adhere to his required duty to stay awake and alert during his shift. The Subject was observed sleeping or motionless and inattentive throughout the night. Most notable was a period of time when the Subject was completely asleep for over ten minutes, in addition to several catnaps lasting upwards of five minutes. Review of the video evidence unequivocally corroborates Nurse [redacted] statements. (Justice Center Exhibits 7, 8 and 16)

In his Request for Amendment and testimony at the hearing, the Subject denied sleeping. However, the Subject consistently wavered in his testimony regarding his attentiveness to routine tasks. At first, the Subject stated that he did what was required of him and then admitted that he did not complete all of his nightly routine tasks. The Subject also admitted to working up to 30 hours in overtime that week, for a total of 70 hours, nearly the equivalent of two full time jobs. Furthermore, the Subject admitted that the nurse had asked him a few times to get up and walk around to help keep him alert. (Hearing testimony of Subject and Facility Risk Manager [redacted]; Justice Center Exhibits 2, 6, 7, 8, 12 and ALJ Exhibit 1)

The Subject's assertion that he did not fall asleep is not credited evidence. It is abundantly

[redacted]

clear from the video that on a number of occasions throughout the shift the Subject was asleep and/or less than attentive. This clear and evident lack of attention breached his duty to the service recipients in his care. Moreover, although there was no evidence that the Subject's breach of duty actually resulted in physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the service recipients, such evidence is not necessary for a finding of neglect. Given that the facility was a psychiatric center's crisis inpatient unit, it is clear that the Subject's failure to provide the required level of supervision, even for a short period of time, was likely to have resulted in physical injury or serious protracted impairment of the service recipients' physical, mental or emotional condition. (Justice Center Exhibit 16)

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.

The next issue 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. A substantiated Category 3 finding 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 NY SSL § 496(2). This report will be sealed after five years.

DECISION: The request of [redacted] that the substantiated report dated [redacted] of neglect by the Subject of

[redacted]

Service Recipients 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 Jean T. Carney, Administrative Hearings Unit.

DATED: October 5, 2016
Schenectady, New York