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 Sardella, Esq.

[redacted]
By: Nicole Murphy, Esq.
Fine, Olin and Anderman, LLP
39 Broadway, Suite 1910
New York, New York 10006

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 granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons Central Register, pursuant to SSL § 493(3)(d).

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: February 2, 2017
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: Sharon Golish Blum
Administrative Law Judge

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

Parties: Vulnerable Persons' Central Register
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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], [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 verify the whereabouts of a service recipient, during which time he eloped from the premises.
>
> 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 facility that is operated by the New York State Office of Mental Health (OMH), which is a provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged neglect, the Subject had been employed by the facility as a Mental Health Treatment Assistant Ward Manager (MHTA 2) for approximately twelve years. The Subject was responsible for supervising the Mental Health Treatment Assistants (MTHAs) who were assigned to her shift and she was supervised by facility Registered Nurses (RNs). The Subject's usual assignment was the evening shift from [redacted]. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged neglect, the Service Recipient was a twenty-nine year old verbal ambulatory male voluntary facility resident of Ward [redacted], with a diagnosis of schizoaffective disorder bipolar type, with a history of substance abuse and self-injurious and suicidal behavior. The Service Recipient was subject to a physical check every thirty minutes. The Service Recipient was permitted to be off site, under the supervision of a program. (Justice Center Exhibit 6) Facility physician's orders provided that the Service Recipient attend various off-grounds group programs including an Interview Skills group on Mondays from 1:00 p.m. until 3:00 p.m. and a Double Trouble group also on Mondays from 3:45 p.m. until 5:15 p.m. (Justice Center Exhibit 13)

7. On [redacted], the Service Recipient signed out of the facility at 1:00 p.m., whereupon he was scheduled to attend the Interview Skills group. He did not sign back in thereafter. (Justice Center Exhibit 10)

8. Unbeknownst to any facility staff, the Service Recipient did not attend either of the groups but, rather, after he signed out of the facility at 1:00 p.m., he loitered outside the group program building, procured synthetic marijuana from someone he encountered, and went to the home of his relatives, where he ate and rested. (Justice Center Exhibit 5)

9. In the meantime, on [redacted], the Subject, who was assigned to Ward [redacted], commenced her shift at 3:30 p.m. and began her first task reviewing the Patient Whereabouts

Accountability Form (Justice Center Exhibit 12) and performing rounds thereafter. The Subject observed that the Service Recipient was marked as "off ward" on the Patient Whereabouts Accountability Form and she inquired of day shift staff as to his whereabouts. Day shift MHTA 1 checked the Doctor's Orders, which indicated that the Service Recipient was scheduled to attend the Double Trouble group and she advised the Subject that the Service Recipient was at the group. The Subject thereafter continued with her regular assigned duties. (Hearing testimony of the Subject and Justice Center Exhibit 5)

10. The Subject inquired no further as to the Service Recipient's whereabouts at the time, as the Off-Ward Schedule, to which she referred, indicated that the Service Recipient was to attend the Double Trouble group on Mondays from 3:15 p.m. until 5:15 p.m. (Hearing testimony of the Subject and Administrative Law Judge Exhibit 1)

11. At some point shortly after 5:00 p.m., the Subject became aware that the Service Recipient had not come to the dining room for dinner, when the other facility residents, who had attended the Double Trouble group, had returned. As a result, the Subject reported to a Ward [redacted] facility RN that the Service Recipient was missing. (Hearing testimony of the Subject)

12. At approximately 2:00 a.m. on [redacted], facility Safety staff located the Service Recipient in front of one of the facility buildings, to which the Service Recipient had returned, and escorted him back to Ward [redacted]. (Justice Center Exhibit 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 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...

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 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 not established by a preponderance of the evidence that the Subject committed neglect as described as Allegation 1 in the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-14) The investigation underlying the substantiated report was conducted by facility Clinical Risk Management Specialist [redacted], who testified on behalf of the Justice Center.

The Subject testified at the hearing and presented evidence in her own behalf. (Subject Exhibits A and B) One other document was admitted into evidence. (Administrative Law Judge Exhibit 1)

A finding of neglect requires, in part, that a preponderance of the evidence establishes that the Subject engaged in conduct that breached her duty to the Service Recipient. In this case, the issue is whether the Subject had a duty to verify the whereabouts of the Service Recipient when she commenced her shift at 3:30 p.m. on [redacted], or at any time thereafter, until she became aware of his absence in the dining room after 5:00 p.m.

The Subject testified that on [redacted], while conducting the patient accountability rounds at approximately 3:35 p.m., she observed that the Service Recipient was marked as "off ward" on the Patient Whereabouts Accountability Form (Justice Center Exhibit 12) and asked day shift staff where he was. The Subject testified that day shift MHTA 1 responded by telling the Subject that the Service Recipient was at the Double Trouble program and, because the Subject

understood that the group program started at 3:15 p.m., she had no reason to seek further verification as to the Service Recipient's whereabouts. The Subject testified that the procedure which was in place to monitor the location of the service recipients was the Change of Shift Ward Report, which required the incoming facility RN assigned to a ward to review the list of service recipients with the outgoing facility RN. (Subject Exhibit A)

The Subject testified that after the start of the evening shift, at 3:30 p.m., on [redacted], a Ward [redacted] facility RN reviewed the Patient Whereabouts Accountability Form (Justice Center Exhibit 12) and that she did not say anything to the Subject regarding the Service Recipient. The Subject testified that she had not been informed by day shift staff that the Service Recipient had not returned to the facility between the Interview Skills and the Double Trouble groups. The Subject testified that it was not until after 5:00 p.m., when the other service recipient Double Trouble group attendees had returned to the facility, that she became concerned and reported the Service Recipient's absence to a Ward [redacted] facility RN.

To support her testimony that, at the time that her shift started at 3:30 p.m., she had no reason to doubt that the Service Recipient was at his Double Trouble group program, the Subject provided the Off Ward Schedule updated on [redacted] (Administrative Law Judge Exhibit 1), which indicates that the Double Trouble group program was to start at 3:15 p.m.

The evidence of day shift MHTA 1 supported the Subject's assertion that she believed that the Double Trouble group began at 3:15 p.m., prior to the commencement of her shift. Day shift MHTA 1 told Clinical Risk Management Specialist [redacted] (Justice Center Exhibit 5, page 5) that when the Subject asked her where the Service Recipient was, she checked the Doctor's Orders, saw that the Double Trouble program began at 3:15 p.m., and so advised the Subject.

Additional ambiguity as to when the Double Trouble group started was raised by the facility Doctor's statement to Clinical Risk Management Specialist [redacted] (Justice Center

Exhibit 5, page 4) that he was sure that he had written the time of 3:45 p.m. in the Service Recipient's orders and, further, by a comment on the Incident Reporting Form (Justice Center Exhibit 6, page 2) prepared by an evening shift facility RN, that staff had thought that the Service Recipient went to the Double Trouble group from 4:00 p.m. until 5:00 p.m. In any case, the Subject's testimony was clear that she understood that the group program had started at 3:15 p.m., and that, therefore, she had no reason to be concerned as to the Service Recipient's whereabouts at 3:30, or anytime thereafter, until she did notice his absence, whereupon she notified her supervisor, a Ward [redacted] facility RN, as required.

The Justice Center argued that, had the Subject checked the Patient Escort/Off Ward Check Sheet (Justice Center Exhibit 10), she would have seen that the Service Recipient had signed out at 1:00 p.m. for the Interview Skills group, and had not signed back in thereafter. The Subject would then have realized that the Service Recipient had not come back between groups, as he should have, and that he had not signed out for the Double Trouble group at all that afternoon. However, no evidence was provided to support this assertion, particularly in light of the Subject's undisputed testimony that she was not the staff who had issued the Service Recipient's pass or signed him out at 1:00 p.m. Furthermore, a review of the Patient Escort/Off Ward Check Sheet reveals that there was poor oversight and enforcement with respect to service recipients signing in and out of the facility, at least on that day, as many of the entries are incomplete and provide little reliable information as to the whereabouts of a number of the service recipients.

There was no further evidence as to the Subject's alleged duty to verify the whereabouts of the Service Recipient. In his testimony, Clinical Risk Management Specialist [redacted] testified only that the Subject should have known that the Service Recipient had not attended the group programs and/or should have verified his whereabouts at the start of her shift. However, this witness failed to articulate any evidentiary basis for his conclusion.

Facility staff would have known of the Service Recipient's absence had the program administration notified the facility that the Service Recipient did not attend the Interview Skills group. The Program Recreation Worker who worked at the group program site told Clinical Risk Management Specialist [redacted] (Justice Center Exhibit 5, page 6) that when the Program Recreation Worker did not have a group, he was responsible for walking around the different groups and notifying the facility when service recipients were not in attendance and, also, that the group leaders were supposed to advise him if a service recipient was missing from a group.

There was compelling evidence that the Program Recreation Worker was obligated to monitor service recipients' attendance and to notify the facility of the Service Recipient's absence, at the time that it arose. However the Program Recreation Worker did not do so and, consequently, appropriate steps to locate the Service Recipient were not undertaken until the Subject became aware of the Service Recipient's absence.

Having had the opportunity to view and consider the Subject's testimony, it is found that the Subject's testimony was credible. That finding, taken together with paucity of the Justice Center's evidence, leads to the determination that the Subject did not have a duty to verify the whereabouts of the Service Recipient, beyond the inquiry that she undertook and, therefore, that the Subject committed no breach of duty. Accordingly, it is concluded that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect under SSL § 488(1)(h), as specified in Allegation 1 of the substantiated report.

DECISION: The request of [redacted] that the substantiated report dated [redacted], [redacted] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

DATED: January 27, 2017
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge