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, of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: January 4, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Todd M. Sardella, Esq.
[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]	**RECOMMENDED DECISION AFTER HEARING**
Pursuant to § 494 of the Social Services Law	**Adjud. Case #:** [redacted]

Before: Brian T. Hughes
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
4 Burnett Boulevard
Poughkeepsie, New York 12601
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: Todd M. Sardella, Esq.

[redacted]
By: Emily Hannigan, Esq.
Lippes Mathias Wexler Friedman LLP
54 State Street, Suite 1001
Albany, New York 12207

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 New York State Social Services Law (SSL) § 494 and Part 700 of 14 New York Codes, Rules, and Regulations (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 failed to provide proper supervision, during which time you were the Charge Nurse responsible for staff assignments and did not assign staff to the bedroom/hallway post.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(a).[1]

Allegation 2

It was alleged that on [redacted], at the [redacted], located at [redacted], while a custodian, you committed neglect when you failed to provide proper supervision and/or medical

[1] Justice Center Exhibit 1b contained a scrivener's error. The proper citation should read "Social Services Law § 493(4)(b)."

treatment, during which time a service recipient was lying on the floor bleeding and unresponsive, and you did not perform an assessment of him.

This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493(4)(b).

3. An Administrative Review was conducted and, as a result, the substantiated report was retained.

4. The facility, [redacted], located at [redacted], provides residential treatment and rehabilitation to adults with serious mental illness and is operated by the New York State Office of Mental Health (OMH), which is an agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 5)

5. At the time of the alleged neglect, the Subject was employed by [redacted] as a Registered Nurse and had been employed by the facility for approximately ten years. (Hearing testimony of Subject) 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 59 years old, and had been a resident of the facility for several months. The Service Recipient was an adult male with a diagnosis of schizoaffective disorder (bipolar type) among other diagnoses. (Justice Center Exhibit 18) The Service Recipient was paranoid and suspicious of others and would often pace the facility's hallways while shadow boxing. (Justice Center Exhibit 18)

7. On [redacted], the Subject was working the evening shift at the facility in Unit [redacted]. (Hearing testimony of Subject; Justice Center Exhibit 6) Unit [redacted] housed [redacted] male service recipients. (Hearing testimony of Subject) Two Mental Health Therapy Aids (MHTA 1 and MHTA 2)[2] and a second registered nurse (RN)[3] were working with the Subject. (Hearing

[2] MHTA 1 was [redacted]. MHTA 2 was [redacted].
[3] RN was [redacted].

testimony of Subject; Justice Center Exhibit 6) The Subject designated as the charge nurse on the shift and was tasked with dispensing medication to the service recipients, supervising staff members, and responding to emergencies and codes. (Hearing testimony of Subject) The Subject was required to complete a shift assignment sheet as part of her duties as the charge nurse. (Justice Center Exhibits 6 and 24) The assignment sheet detailed each staff member's specific duties on the unit. At the time of the alleged neglect, MHTA 1 was assigned to bedroom/hallway coverage but the Subject left that assignment blank on the assignment sheet. (Justice Center Exhibit 6)

8. At approximately 9:15 p.m. that night, both the Subject and the RN were in the nursing office located to the rear of the nursing station. The nursing station was located at the terminus of a long hallway and a short hallway. The Subject was completing medical notes with the RN after having distributed scheduled medications to the service recipients earlier in the night. MHTA 1 was seated inside the nursing station facing the short hallway. (Hearing testimony of Subject; Justice Center Exhibit 27: audio of interview of MHTA 1)

9. The Service Recipient had been walking down the hallway away from the nursing station when he entered the doorway to a bathroom occupied by SR2. The Service Recipient suddenly punched SR2 in the face. Immediately, SR2 retaliated and punched the Service Recipient. The Service Recipient fell backward and onto the floor as SR2 proceeded to repeatedly punch him in the head. As the assault continued, SR3 walked out of the bathroom and toward the nursing station while calling for help. SR2 briefly stopped the assault to return to the bathroom while the Service Recipient lay motionless on the floor facing away from the nursing station. (Justice Center Exhibit 27: video of incident)

10. SR2 then emerged from the bathroom a second time and proceeded to stomp the Service Recipient's head against the floor sixteen times. (Justice Center Exhibit 27: video of

incident) MHTA 2 heard SR3 call for help and ran to the scene of the attack from the dayroom. (Justice Center Exhibit 27: audio of interview of MHTA 2) The Subject walked to the scene of the assault in the long hallway following MHTA 2. (Justice Center Exhibit 27: video of incident) MHTA 2 pushed SR2 away from the Service Recipient and down the hallway. (Justice Center Exhibit 27: audio of interview of MHTA 2) As the Subject walked down the hallway she instructed the RN to activate a Code Green and retrieve the crash cart. (Hearing testimony of RN) MHTA 2 instructed SR2 to sit at the end of the long hallway and SR2 complied. (Justice Center Exhibit 27: audio of interview of MHTA2) The Subject continued to walk down the hallway but stopped short of reaching the Service Recipient. At that point, the Service Recipient was bleeding from his head and lay motionless on the floor with his back to the Subject. (Justice Center Exhibit 27: video of incident)

11. The Subject then turned about face and walked back toward the nursing station. MHTA 1 and SR3 began to walk toward the Service Recipient from the nursing station. The Subject motioned with her arms for MHTA 1 and SR3 to walk away from the scene. SR3 ignored the Subject's directive and walked to within several feet of the Service Recipient before eventually turning around and walking back toward to the nursing station. (Justice Center Exhibit 27: video of incident)

12. Subsequently, SR2 then returned to his feet and assaulted the Service Recipient a third time. (Justice Center Exhibit 27: audio of interview of MHTA) MHTA 1 and MHTA 2 then intervened and stopped the attack. (Justice Center Exhibit 27: video of incident)

13. Simultaneously, the RN called security to inform them of the Code Green and then left the nursing station to retrieve the crash cart. (Hearing testimony of RN) The RN began to walk to the room containing the crash cart but then turned around and returned to the area directly

in front of the nursing station. After speaking with someone in the nursing station the RN walked back to the crash cart room and retrieved the crash cart and responded to the Service Recipient. (Justice Center Exhibit 27: video of incident)

14. Prior to the RN arriving on scene, the Nurse Administrator[4] arrived from different floor. (Justice Center Exhibit 27: video of incident) Upon arriving, the Nurse Administrator immediately began an assessment of the Service Recipient and yelled for a Code Blue. (Justice Center Exhibit 27: interview audio of Nurse Administrator) The Service Recipient was transported to the hospital and ultimately passed away on [redacted], due to cardiopulmonary arrest and ventilator associated pneumonia. (Justice Center Exhibit 5)

15. At the time of the alleged neglect, the facility's Policy and Procedure Manual (the Policy) required a unit's nurse to administer first aid when indicated. (Justice Center Exhibit 25) The Policy required that the most qualified person remain with the injured person while other staff notify Safety of the emergency. (Justice Center Exhibit 22) All staff are trained and allowed to call Security and request a Code Blue during a medical emergency. (Justice Center Exhibit 21)

16. A Code Green is an emergency call for assistance in response to a psychiatric emergency within the facility. Available staff are required to respond to a Code Green. (Justice Center Exhibit 20) A Code Green can be initiated either by calling security via a landline or by pushing a button on a personal alarm (PAL) device worn by staff. When activated, the PAL device issues a Code Green and automatically reports the staff member's location within the facility to security. (Justice Center Exhibit 19)

17. In contrast to a Code Green, a Code Blue is an emergency call in response to a medical emergency. (Justice Center Exhibit 20) A Code Blue can only be reported via a landline.

[4] The Nurse Administrator was [redacted]

(Hearing testimony of RN) During a Code Blue appropriate emergency medical services (EMS) personal are dispatched to the incident. (Justice Center Exhibit 20)

18. The Policy also required the charge nurse to ensure that patient monitoring and census checks are done during the shift. The stated purpose of the monitoring and checks was to ensure that patients were always supervised. (Justice Center Exhibit 26) The charge nurse was required to complete the staff assignment sheet for the shift to comply with the Policy. The Policy required that "[d]uring and at the end of the shift, the Charge Nurse/Designee is responsible for ensuring that all assignments have been completed… ." (Justice Center Exhibit 24) The Policy required that staff assigned to the bedroom/hallway coverage place themselves in areas that they can continuously observe patient movements. (Justice Center Exhibit 24)

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 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 abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 2, which is defined as follows:

> (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one 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 not established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report but has establish by a preponderance of the evidence that the Subject committed neglect as described in "Allegation 2" of the substantiated report.

In support of its substantiated findings, the Justice Center presented several documents obtained during the investigation. (Justice Center Exhibits 1 through 26) The Justice Center also presented audio recordings of the Justice Center Investigator's interview of witnesses and interrogation of the Subject, and surveillance video of the incident from within the facility. (Justice Center Exhibit 27) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who testified at the hearing on behalf of the Justice Center. The Subject testified in her own behalf.

Allegation 1 - Neglect

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 Justice Centered alleged that the Subject breached her duty to provide proper supervision by failing to assign a staff member to bedroom/hallway coverage in the facility. The

Subject argued in her defense that she had assigned MHTA 1 to bedroom/hallway coverage but neglected to document the assignment on the staff assignment sheet. (Hearing testimony of Subject)

The Justice Center submitted the relevant portions of the facility's Policy and Procedure Manual (the Policy) that clearly established the Subject's duty to supervise. (Justice Center Exhibits 19-26) The Policy required that the charge nurse ensure that patient monitoring was done during the shift in case a patient required immediate assistance. (Justice Center Exhibit 26) Accordingly, the charge nurse was required to complete a staff assignment sheet that documented, inter alia, the specific staff member responsible for patient monitoring. (Justice Center Exhibit 24) However, the Justice Center did not establish a breach of the Subject's duty to supervise.

The Justice Center presented the staff assignment sheet submitted by the Subject as evidence of the alleged breach of duty. Notably, the Subject left the bedroom/hallway coverage assignment blank on the sheet. (Justice Center Exhibit 6) However, the Justice Center's evidence was rebutted by the testimony of the Subject and the audio of the interview of MHTA 1. The Subject testified that MHTA 1 was assigned to both census and the bedroom/hallway coverage at the time of the alleged neglect. The Subject further explained that the Nurse Administrator approved the staff assignment sheet. (Hearing testimony of Subject)

The Subject's account regarding the coverage for bedroom/hallways was corroborated by the audio of the interview of MHTA 1. During his interview, MHTA 1 stated that he was assigned to bedroom/hallway coverage at the time of the incident. MHTA 1 further described that he positioned himself inside the nursing station to observe both the short hallway and a portion of the long hallway on the unit. (Justice Center Exhibit 27: audio of interview of MHTA 1) The surveillance video showed MHTA 1 responding to the assault in the long hallway by exiting the

nursing station from the nursing station doorway closest to the short hallway. (Justice Center Exhibit 27: video of incident) Lastly, MHTA 1's statement was credible because the statement was against his own interest. The statement from MHTA 1 reflected potential negligence in the performance of his duty because he failed to observe the assault during the time he was assigned to bedroom/hallway coverage. Thus, there was credible evidence that the Subject assigned MHTA 1 to bedroom/hallway coverage during the time of the alleged neglect. As a result, the Justice Center did not establish that the Subject failed to assign staff to the bedroom/hallway coverage and thus did not breach her duty to provide supervision of the service recipients.

Accordingly, it is determined that the Justice Center did not meet its burden of proving by a preponderance of the evidence that the Subject committed the neglect as alleged.

Allegation 2 - Neglect

Next, the Justice Center argued that the Subject committed neglect by failing to provide medical treatment to the Service Recipient while he lay on the floor, bleeding and unresponsive. The Subject countered that she responded adequately to the Service Recipient and did not conduct an assessment because she suspected that the Service Recipient had a head injury. The Subject's argument is without merit.

The Justice Center argued that the Subject had a duty to provide medical treatment to the Service Recipient. The relevant portion of the facility's Policy on patient care required a unit's nurse to administer first aid when indicated. (Justice Center Exhibit 25) The facility's Policy also required the most qualified person remain with the injured person while other staff notify Safety of the emergency. (Justice Center Exhibit 22) The Subject, as the Unit's charge nurse, was clearly the most qualified person to render assistance to the Service Recipient at the time of the incident. The surveillance video also provided compelling evidence that the Service Recipient required first

aid as he lay motionless and bleeding on the floor. (Justice Center Exhibit 27: video of incident) Plainly, the Subject had a duty as a custodian to render first aid to the Service Recipient, or at the very least, remain with the injured Service Recipient while other staff sought assistance.

The Justice Center presented the surveillance video from the facility to show how the Subject's inaction during the incident equated to a breach of her duty. More specifically, the Justice Center argued that the Subject's failure to conduct an assessment constituted a breach of the duty to provide medical treatment to the Service Recipient. The video showed how the Subject walked toward the Service Recipient with visible hesitation and stopped several feet short of the motionless Service Recipient. At the time, the Service Recipient was lying on the floor in a fetal position with his back to the Subject after having been violently assaulted by SR2. At no point did the Subject conduct any observable assessment of the Service Recipient. Rather, the Subject merely glanced at the Service Recipient for a split second and then abruptly turned and retreated to the nursing station without any visible sense of urgency. (Justice Center Exhibit 27: video of incident)

It was obviously not possible for the Subject to assess the condition or extent of the Service Recipient's injuries from the positioning of the Service Recipient on the ground vis-à-vis the Subject . The Subject did not attempt any basic first aid, such as checking the Service Recipient's breathing or stemming the bleeding. The Subject's excuse for not conducting an assessment because of a suspected head injury to the Service Recipient was unconvincing and in contradiction to the facility's policy to render first aid. (Justice Center Exhibit 23) The Subject made no attempt to render even the most basic or minimally evasive amount of first aid to the Service Recipient. The Subject indefensibly abandoned Service Recipient while he remained unconscious and injured on the floor. The Subject's inaction unquestionably breached her duty to provide medical

treatment to the Service Recipient.

Furthermore, the Subject's failure to perform an assessment was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The Subject's failure to assess the Service Recipient resulted in the Service Recipient remaining on the floor unconscious while in need of immediate emergency medical attention. Clearly, the Subject's abandonment of the Service Recipient during the medical emergency was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Accordingly, it is determined that the Justice Center 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 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 2 act. Category 2 conduct is defined as conduct in which the Subject seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b)) The Subject's failure to assess the Service Recipient during a medical emergency left the Service Recipient bleeding and unconscious on the floor, which seriously endangered the Service Recipient's health safety and welfare. 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 2 act.

A Category 2 act under this paragraph shall be elevated to a Category 1 act when such an act occurs within three years of a previous finding that such custodian engaged in a Category 2 act. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

DECISION: The request of [redacted] that Allegation 1 of the substantiated report dated [redacted], be amended and sealed is granted with respect to Allegation 1. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

The request of [redacted] that Allegation 2 of the substantiated report dated [redacted], be amended and sealed is denied with respect to Allegation 2. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized, as a Category 2 act.

This decision is recommended by Brian T. Hughes, Administrative Hearings Unit.

DATED: December 18, 2018
Schenectady, New York

Brian T. Hughes, ALJ