NEWS RELEASE

From New York State Acting Inspector General
Catherine Leahy Scott

FOR IMMEDIATE RELEASE:
September 27, 2012

OFFICE OF MENTAL HEALTH OFFICIAL COERCED SUBORDINATES TO DECEIVE OVERSIGHT AGENCY, AND COVER UP FAULTY DISCHARGE POLICY PUTTING KINGSBORO PSYCHIATRIC RESIDENTS AT RISK

Investigation Results in Enhanced, Uniform Discharge Policies

Acting New York State Inspector General Catherine Leahy Scott announced the completion of an investigation which found officials at the Kingsboro Psychiatric Center allowed the release of residents from the facility without a required discharge plan. The investigation also revealed that the acting Deputy Director of Program Operations later directed staff to falsify discharge plan records to cover up the lapse in procedure.

The Inspector General's office is referring the case to the Kings County District Attorney and the State Joint Commission on Public Ethics. The Inspector General has also recommended that the state Office of Mental Health (OMH) strengthen discharge procedures and discipline staff implicated in the investigation.

"Discharge plans exist for a reason," said Acting Inspector General Scott, "to protect the health and safety of residents being released. This failure put innocent people at risk, and that is unacceptable."

The investigation stemmed from a July 2011 complaint to the Inspector General by the State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC), that following its investigation into improper discharges, it received documents falsely claiming that discharge procedures were followed, when they were not.

As a result of its findings at Kingsboro PC, the Inspector General's office conducted a system-wide review of OMH facilities and found inconsistent and sometimes deficient discharge procedures.

OMH regulations on patient discharge require the development of an initial discharge plan upon a resident's arrival. According to Kingsboro PC policy, plans are reviewed weekly and revised when necessary. Residents' progress and the availability of housing options are supposed to be discussed at these weekly meetings.

As part of its care delivery system, Kingsboro PC maintains Transitional Living Residences, one of which is Mary Brooks TLR. TLRs provide on-site lodging, care and treatment for residents preparing to transition to the community. Residents may live at a TLR anywhere from a few weeks to several years. During their stay, OMH assesses residents' housing, financial and psychiatric needs, and formulates plans for community placement.

In a May 2010 investigation of a complaint regarding an April 2010 resident discharge, CQC determined Kingsboro PC had inappropriately discharged a Mary Brooks TLR resident on a street corner near a shelter. The

Inspector General's investigation began after CQC's discovery of the falsified discharge documents in a 2011 follow-up review of its own.

After this egregious discharge, the Inspector General's investigation found that Tanya Priester, then Acting Deputy Director of Program Operations at Kingsboro Psychiatric Center, compelled staff to sign resident discharge forms in an effort to deceive CQC that policies had been followed. Although Kingsboro PC advised CQC in September 2010 that a new policy to address obvious deficiencies in the discharge process would be instituted, Kingsboro PC failed to do so. The Inspector General's investigation further found that discharge policies at a number of OMH facilities fail to comply with OMH regulations.

The Inspector General recommended that OMH:

- Discipline Priester and other Kingsboro PC officials as appropriate;
- Promulgate uniform discharge policies that include a verifiable review and pre-approval requirement by management;
- Review Kingsboro and Mary Brooks TLR discharge plans; and
- Conduct periodic audits to ensure compliance at all the TLRs it oversees.

OMH has indicated it has disciplined Priester and other Kingsboro PC staff. In response to this report OMH is reviewing for implementation the Inspector General's recommendations with respect to discharge policies. OMH will advise the Inspector General within 90 days on its implementation.

CQC Chair Roger Bearden said: "We appreciate the Inspector General's thorough investigation into the falsified documents provided to our investigators. To improve the quality of care for persons with disabilities, it is vital that the agencies we oversee provide truthful and accurate information to our investigators."

The Inspector General has referred its report to the Kings County District Attorney and the State Joint Commission on Public Ethics, as Priester's actions may constitute a violation of New York State's Penal and Public Officers laws.

A copy of the report can be found online by clicking **here**.

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