STATE OF NEW YORK
OFFICE OF THE STATE INSPECTOR GENERAL
Final Report
September 27, 2012

SUMMARY OF FINDINGS/RECOMMENDATIONS

The New York State Inspector General found that on April 6, 2011, Tanya Priester, then Acting Deputy Director of Program Operations at Kingsboro Psychiatric Center (Kingsboro PC), a New York State Office of Mental Health (OMH) facility, compelled subordinate staff to sign resident discharge forms in an effort to deceive the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) regarding new policies promulgated after CQC found systemic deficiencies in the resident discharge process.

The Inspector General further found that, 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 also found that discharge policies at a number of OMH facilities fail to comply with OMH regulations.

The Inspector General recommends that OMH discipline Priester and other Kingsboro PC officials as appropriate. The Inspector General will also provide these findings to the Kings County District Attorney.

The Inspector General further recommends that OMH promulgate uniform discharge policies which comply with regulations and include a verifiable review and pre-approval requirement by management of all discharges. OMH also should conduct periodic audits to ensure compliance.

The Inspector General advised OMH of the findings and recommendations herein. 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 ninety days of the outcome of said review and implementation. Further, OMH has taken disciplinary action against Priester and other Kingsboro PC officials.

ALLEGATION

On July 15, 2011, the New York State Inspector General received a complaint from CQC, which alleged that following a May 2010 CQC investigation regarding an improper discharge at Kingsboro PC, Kingsboro PC provided to CQC fraudulent documents that purported to reflect review and approval of resident discharge plans by supervisory staff of Mary Brooks Transitional Living Residence (Mary Brooks TLR) when, in fact, no such review had taken place.

SUMMARY OF INVESTIGATION

Background

Kingsboro PC, an OMH facility in Brooklyn, provides psychiatric care to individuals with serious mental illness. It maintains in-patient and out-patient programs, including hospitalization, crisis intervention, transitional living, family care, and satellite community-based clinics. During the period relevant to this investigation, James McCummings served as Executive Director responsible for all Kingsboro PC operations.[1]

Among its services, Kingsboro PC maintains Transitional Living Residences, one of which is Mary Brooks TLR. Transitional Living Residences provide on-site lodging, care and treatment for residents preparing to transition to the community. Residents may live at a TLR for periods ranging anywhere from a few weeks to several years. During their stay, residents' housing, financial and psychiatric needs are assessed and plans for placement in the community are formulated. At any one time, Kingsboro PC serves a patient population of approximately 845 individuals, some 45 of whom are residents of Mary Brooks TLR.

OMH regulations governing patient discharge require the development of an initial discharge plan upon a resident's arrival.[2] According to Kingsboro PC policy, plans are reviewed weekly thereafter at meetings coordinated by the Office of Discharge Planning, and revised when necessary.[3] Residents' progress and the availability of housing options are discussed at these weekly meetings.

In a May 2010 investigation of a complaint regarding an April 2010 resident discharge, CQC determined that Kingsboro PC had inappropriately discharged a Mary Brooks TLR resident. Specifically, CQC's investigation revealed that after a resident had rejected numerous attempts by Kingsboro PC to find a community placement and failed to adhere to Mary Brooks TLR rules, the resident was taken by Kingsboro PC staff and simply left on a street near a local shelter. This egregious action by Kingsboro PC violated both due process provisions of OMH

[1] McCummings retired effective May 31, 2012.
[2] OMH discharge planning is governed by OMH regulation 14 NYCRR 595.9, which is discussed is greater detail later in this report.
[3] NYS OMH Kingsboro PC Mary Brooks TLR Discharge Policy, p. 42, effective 7.14.10. The Inspector General notes that two types of meetings were held at which discharge plans were discussed: "Bed meetings" held weekly at the Mary Brooks TLR and "Discharge meetings" held weekly at Kingsboro PC. For the purposes of this report, the two will be referred to collectively as "discharge meetings."

regulations and Mary Brook TLR Housing Agreements, which require that a resident be given a written 30-day notice final notice of intent to terminate residency as well as follow-up aftercare planning and grievance procedures, among other things.[4] Upon discovery of this improper discharge, the resident was returned to Kingsboro PC, and all employees determined to have been involved in the incident were demoted, reassigned or counseled.

CQC consequently recommended policy and procedural changes to address the issue. On September 8, 2010, Kingsboro PC Executive Director James McCummings advised CQC that it would strengthen its discharge review process. Shortly thereafter, Kingsboro PC provided CQC its Policy Directive Memo addendum, dated September 13, 2010, issued by Tanya Priester (then Acting Deputy Director of Program Operations),[5] in which Priester directed that all resident discharge plans be reviewed by the Chief of Community Services and the Director of Social Work prior to the actual discharge of the resident.

By letter dated September 21, 2010, CQC's Division of Quality Assurance and Investigations informed Executive Director McCummings that it had formally closed the investigation into the improper discharge. In the letter, CQC noted:

> You informed us on September 8, 2010, that any further discharges will be reviewed and approved by Ms. Tanya Priester for appropriateness and for following proper discharge procedures prior to any resident being discharged from the Mary Brooks Residence. We were also informed that Janis Gordon, the Director of Discharge Planning and Acting Director of Social Work will also review all future discharges for approval. We have received documentation verifying this information.

Specifically, the policy addendum read: "This addendum to the Mary Brooks discharge process does not alter the previous correspondence in which the Chief of Community Services [Deborah Jordan] and the Director of Social Work must review all upcoming discharges for their approval.[6] As previously indicated, Ms. Janis Gordon will be acting in the capacity of Director of Social Work." It is important to note that neither the memo nor prior practice described the methodology and mechanism for reviewing and approving upcoming discharges, including any requirement that the discharge form be signed.[7] This new policy was e-mailed to pertinent staff; however, employees were not required to acknowledge their receipt and review of the policy addendum. Significantly, as will be detailed below, despite McCummings's representations to CQC regarding the newly promulgated policy and its dissemination, it was not implemented.

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[4] See, 14 NYCRR 595(c)(3) and Mary Brooks TLR Housing Agreement.

[5] In October 2011, in light of CQC's findings, OMH removed Priester from the title of Acting Deputy Director of Program Operations and placed her in a Treatment Team Leader title, pending the results of the Inspector General's investigation.

[6] The Inspector General reviewed relevant prior Kingsboro policies addressing resident discharges but found neither policy nor "previous correspondence" that directed the Chief of Community Services and the Director of Social Work to review and approve all upcoming discharges.

[7] Indeed, the discharge form used at this time contained no signatory lines.

CQC's Review of Kingsboro PC Mary Brooks TLR Discharges

In January 2011, CQC sought to determine if Kingsboro PC had complied with its September 2010 representation that it had implemented its revised discharge protocol which included review of discharges by Gordon and Jordan. As part of this review, CQC requested from Gordon a list of all residents discharged from Mary Brooks TLR since September 18, 2010, along with documentation that the discharges had been reviewed and approved by Gordon and Jordan. According to CQC, however, Gordon replied that she was unaware of both the new procedure and any role she was to have in reviewing and approving discharges. CQC then requested the documentation from Priester.

Several days later, Priester provided CQC with 35 "Mary Brooks TLR Discharge Forms" which appeared to reflect discharge plans for residents discharged between September 2010 and January 2011. The discharge forms contained each resident's name, discharge date, discharge address and after-care plan. These forms purportedly had been completed and submitted to the Treatment Team Leader and Social Work Supervisor prior to the residents' discharges. Of note, the discharge forms, which were listed as copied to Priester, Gordon and Jordan, contained no signatures. CQC then reported to Priester that the forms lacked signatures or any other evidence indicating that the required review and approval by the Chief of Community Services and the Director of Social Work had indeed occurred.

On April 6 and 7, 2011, CQC investigators made an unannounced visit to the facility to conduct interviews of relevant personnel and review records pertaining to Mary Brooks TLR discharges. Upon arrival at the facility on April 6, 2011, CQC staff again requested the Mary Brooks TLR Discharge Forms for the above-stated period. It was not until the second day of the audit that Kingsboro PC eventually provided CQC with a binder of discharge forms. The original forms were not the same as the copies earlier provided to CQC by Priester. Indeed, in direct contrast to the same batch of discharge forms previously received by CQC that had no signatures, all the forms in the binder now contained the signatures of Rose Laveau, the Mary Brooks TLR Treatment Team Leader, Priester, and Jordan, and a number included Gordon's signature as well. Although the signatures were undated, the "new" forms appeared to reflect that the discharge reviews had occurred.

Noting this discrepancy, CQC conducted interviews of relevant staff. According to CQC records, Executive Director McCummings stated that Kingsboro PC had yet to implement the new discharge review policy, despite his representations in September 2010 that the new plan was being implemented. Priester and Laveau, however, claimed to CQC that discharge reviews had taken place, and that the forms had been circulated and signed at the discharge meetings prior to the discharge of the involved residents in accordance with the new policy. Gordon, too, reported that the discharge review process had taken place. These answers were puzzling, as Gordon had claimed ignorance of the new policy in January 2011 in response to CQC's inquiry, yet her signature appeared on discharge forms for discharges which had occurred from November 2010 to January 2011.

Further review by CQC revealed that Priester's signature also appeared on discharge forms during a period Priester was absent from the facility due to personal reasons.

In addition, Judith Okoli, the Director of Social Work from December 2010 to April 2011, told CQC that she had never seen the September 2010 memo outlining the new discharge process. Okoli further reported that, although she had attended discharge meetings, she had never seen the discharge form, nor had she seen anyone sign a form during these meetings.

Jordan, the Chief of Community Services, provided CQC with the most damning assertions regarding the discharge review process and the signed discharge forms. Specifically, Jordan stated there had been no review and approval by either her or Gordon prior to patient discharges, and the forms at issue had not been signed before the discharges. Moreover, and most troublesome, Jordan claimed that Priester had summoned her on April 6, 2011, to sign the forms, which she did. Explaining her actions, Jordan asked CQC: "What are you supposed to do when your supervisor tells you to do something?"

Given this troubling and contradictory evidence, CQC referred the matter to the Inspector General for further review.

THE INSPECTOR GENERAL'S INVESTIGATION

The Inspector General investigated actions occurring at Kingsboro PC from September 2010 through April 2011. The Inspector General's investigation was three-pronged: (1) to determine if Mary Brooks TLR discharges were in compliance with its newly reformed discharge policy that resulted from CQC's investigation findings; (2) to ascertain if Kingsboro PC staff provided accurate information to CQC during its subsequent audit; and (3) to review discharge policies at other similar facilities.

New Discharge Review Policy Not Fully Implemented

In order to ensure Kingsboro PC was in compliance with its September 2010 policy addendum discussed above, the Inspector General reviewed discharge forms, tracking logs, meeting notes and e-mails, and obtained sworn testimony from staff involved in the discharge process.

At the outset of its investigation, the Inspector General compared the unsigned discharge forms provided to CQC in January 2011 and the signed forms provided during CQC's April 2011 visit to the facility. Significantly, the Inspector General found that Priester's signature appeared on a number of discharge forms despite the fact she was on leave during times when the relevant discharge reviews occurred.[8] In addition, even though in January 2011 Gordon claimed to CQC that she had never been told of the new discharge procedure, her signature appears on a number of forms relating to discharges which occurred prior to this date. Lastly, although Okoli was

[8] Priester was absent from Kingsboro PC in excess of 45 days during the period at issue, yet her signature appears on numerous discharges that took place in her absence.

Acting Director of Social Work from December 2010 through CQC's April 2011 audit, her signature does not appear on any of the discharge forms.

Given the strong inference of fraudulent discharge reviews, the Inspector General requested that McCummings produce all records relating to discharge meetings, including sign-in sheets and minutes, to determine if the Chief of Community Services and the Director of Social Work had in fact conducted a review and approved each discharge plan prior to a resident's departure.[9] McCummings responded to the Inspector General that minutes had not been taken for discharge meetings held during the period in question. McCummings further stated that sign-in sheets for discharge meetings were taken as a practice by the facility, but had been lost when the staff changed offices.[10]

Having no documentary evidence to determine who attended discharge meetings and whether residents' plans were reviewed and approved, the Inspector General obtained informal meeting notes and tracking logs from discharge meeting attendees for the period September 2010 through March 2011. A review of these notes found no evidence that the Director of Social Work (Gordon) attended any discharge meetings when she returned from her leave of absence. Moreover, Gordon testified she was not aware prior to April 2011 of the policy change requiring her review and approval of upcoming discharges. Indeed, in response to a written request from the Inspector General for documentation reflecting her or a designee's attendance at any discharge meetings during the period at issue, Gordon wrote, "[P]lease be informed that I was not given a directive during the period specified to attend discharge planning meetings, to sign off on my attendance and to participate in the specified review of discharge supervisory forms for the KPC transitional residences."[11]

With regard to Jordan's attendance at discharge meetings, according to meeting notes, Jordan attended numerous meetings where the discharge plans were reviewed. Jordan, consistent with her statement to CQC, testified to the Inspector General that she attended discharge meetings, reviewed discharge plans and was aware of the discharge form during the period at issue. Nevertheless, Jordan advised that the discharge forms were not passed around for signatures during these meetings.

Of note, the Inspector General reviewed a sampling of discharges which occurred after April 2011. This review found documentation that the Chief of Community Services and the Director of Social Work had reviewed and approved resident discharges as required in the new policy.

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[9] The Inspector General also searched for evidence that representatives of the offices of Chief of Community Services and Director of Social Work had attended meetings and acted in their stead, but no such evidence was found.

[10] As a practice, Kingsboro PC, since August or September 2011, began to record minutes for discharge meetings.

[11] Likewise, Constance Pitt, a Social Work Supervisor, who attended almost all discharge meetings on Gordon's behalf during Gordon's seven week absence in late 2010, said she was unaware of the September 2010 policy change and did not review and approve discharge plans. Pitt reported to the Inspector General that she merely provided status updates and fielded questions.

Priester Compelled Subordinate Staff to Complete Documents Belatedly in an Effort to Conceal Kingsboro PC's Failure to Implement New Discharge Review Policy

In light of the lack of documentation supporting compliance with the discharge review policy and Jordan's statement to CQC in April 2011 that Priester had compelled her to sign the discharge reviews well after the fact, the Inspector General obtained sworn testimony from the relevant parties regarding the signed discharge forms obtained by CQC during its unannounced April 2011 visit.

Testimony of Rose Laveau

Rose Laveau, the Mary Brooks TLR Treatment Team Leader, is responsible for the management of the residence. In April 2011, Laveau represented to CQC that the new discharge policy had been implemented since October 2010 and that since that time, reviews had taken place and discharge forms had been signed. However, testifying under oath to the Inspector General, Laveau testified that although she attended discharge meetings regularly, she was not aware of any discharge form being utilized during the period at issue.

Laveau further testified that on April 6, 2011, she was summoned to Priester's office and asked to bring the Mary Brooks TLR binder, which contained all unsigned discharge forms. Laveau said she was instructed to leave the binder and forms with Priester.[12] Similar to Jordan's version of events, Laveau said that later that evening she was called back to Priester's office and told by Priester, "You have to sign these." Laveau noted that when she signed the documents, they already contained Priester's signature. When the binder was subsequently returned to Laveau, the forms contained four signatures: those of Gordon, Jordan, Priester and Laveau.[13] Of Priester's demands for signatures, Laveau told the Inspector General: "I didn't feel comfortable."

Testimony of Janis Gordon

Gordon's testimony to the Inspector General both mirrored and bolstered Laveau's testimony. Gordon stated that she occasionally attended discharge meetings but had no knowledge of the discharge form prior to CQC's April 2011 visit. Gordon, who appeared visibly upset, described to the Inspector General her meeting with Priester on April 6, 2011, to which Priester summoned her. Gordon said that Priester told her to sign the forms because – according to Priester – the forms should have been signed at the respective discharge meetings. Gordon said she reluctantly agreed to sign the forms, but told Priester: "I cannot sign the forms that represent the period of time that I was away." According to Gordon, although Priester continued to instruct her to sign all of the discharge forms, she did not sign forms for discharges which occurred when she was on leave. As a consequence of Priester's demands, although Gordon's tenure as Acting Director of Social Work ended in December 2010, Gordon's signature appeared

[12] Laveau testified she was summoned to the office by either Priester or Priester's secretary. The secretary told the Inspector General that she had no recollection of summoning Laveau, but did remember that a binder of discharge forms had been placed on her desk with instructions to return it to Laveau.

[13] The discharge forms contained all four signatures except for Gordon's signature for the period from mid-September to mid-November 2010, when she was absent from the facility.

on forms dated until April 2011. If, in fact, the new policy had been implemented and followed, forms used after December 2010 would have appropriately been signed by the then-Acting Director of Social Work, Okoli.

Testimony of Deborah Jordan

According to her testimony, Jordan, while attending a business meeting in Manhattan on April 6, 2011, received a telephone call from Priester. Priester requested that Jordan return to Kingsboro PC to sign the discharge forms. Jordan reported that when she arrived at Priester's office, Gordon was present and was "balking" at signing the forms, as Gordon had been absent from the facility for a period and had not attended all discharge meetings. When Jordan arrived at the office, Priester presented a binder containing discharge forms to Jordan, and asked Jordan to sign them. Jordan did so, although she thought it was a "peculiar" request and she felt uncomfortable signing the documents.

Testimony of Judith Okoli

Okoli's testimony undermined Priester's claims to CQC that a discharge review and approval process was ongoing during the period in question. Okoli testified that sometime after she became the Acting Director of Social Work in December 2010, she received a copy of the new discharge policy via e-mail. Okoli attended weekly discharge meetings after this date, but testified she was unaware of the discharge form. "I didn't even know what this form was," she said, "And I had not seen this form up until [CQC's April 2011 audit]." Supporting Jordan's testimony to the Inspector General, Okoli recalled being present during an April 6, 2011 telephone call between Priester and Jordan, after which Jordan informed Okoli that Priester "was discussing some type of discharge form that apparently . . . she needed [Jordan] to either create them or sign-off . . . that there had been a discharge form when there hadn't been a discharge form. And [Jordan] was very upset about this . . . because apparently this is something that she is being ordered to do by Tanya [Priester], her immediate supervisor, and she was very disturbed by it."

Testimony of Tanya Priester

Priester was interviewed by the Inspector General. When confronted with the above testimony, Priester testified that all other staff had lied to the Inspector General under oath, and provided her own account of the events regarding Kingsboro PC's implementation of the new discharge policy and the events of April 6 and 7, 2011. Priester testified the discharge form was introduced after CQC's September 2010 review, was circulated thereafter at discharge meetings, and was signed by all required to do so: Gordon and Jordon. She denied ever summoning Gordon, Jordan or Laveau to her office and instructing them to sign the forms. Thus, according to Priester, the new discharge policy had been fully implemented after September 2010, and no effort had been made to deceive CQC by altering documents. This testimony not only was contradicted by the testimony of Priester's colleagues but was belied by the documentary evidence discussed above. As such, the Inspector General concluded that Priester, while under oath, testified untruthfully during this investigation.

The Inspector General's Review Finds Some Facility Discharge Procedures Insufficient

Discharge planning and procedures for individuals making the transition from a psychiatric facility to the community must comply with OMH regulations.[14] These regulations require a discharge planning process be in place upon a resident's admission to a transitional residence and continue throughout the resident's stay. The process must include, at a minimum, involvement of the resident, staff and community service providers; clinical assessment of the resident's psychiatric status and rehabilitation; needs and goals planning; and community placement options, referrals and appointments. Voluntary discharges can only take place after all discharge planning activities have been fully followed, appropriate alternative housing has been identified, and the resident is willing to relocate to such housing. Involuntary discharges can only occur in certain circumstances and only after due process procedures have been implemented. OMH policy (PC-400) requires that each psychiatric facility develop written procedures for discharging residents consistent with the requirements of the regulations. The policy also requires a written discharge plan for each resident as well as agreements between the state and local government entities for the provision of services to each resident upon discharge.

In light of the findings of serious problems at Kingsboro PC and the potential ramifications of failure to maintain a proper discharge protocol, the Inspector General assessed discharge planning on a system-wide basis, reviewing resident discharge procedures at the other 12 OMH psychiatric centers which operate Transitional Living Residences (TLRs) or Transitional Placement Programs (TPPs). This review revealed that procedures varied significantly among facilities.

The Greater Binghamton Health Center TLR was found to have established the most comprehensive discharge procedures. The procedures describe the criteria for both voluntary and involuntary discharges, and include specific instructions for accomplishing both.[15] In addition, the procedures contain all necessary forms to ensure due process in involuntary discharges. While less comprehensive, seven other facilities have established discharge procedures which appear to meet the minimum requirements of the regulations. These include Rockland Psychiatric Center's Middletown Transitional Placement Program (TPP), Southbeach Psychiatric Center TLR, Rochester Psychiatric Center's Elmwood TLR, Pilgrim Psychiatric Center's TPP, Manhattan Psychiatric Center's TLR, Capital District Psychiatric Center and Bronx Psychiatric Center's TLR.

The Inspector General's review identified four facilities whose discharge procedures are deficient in some respect. Both Hudson River Psychiatric Center's Clearwater Residence (now operated by Rockland Psychiatric Center), and Creedmore Psychiatric Center's TTP lack procedures for voluntary discharge. Mohawk Valley Transitional Living Center only maintains a discharge summary form but lacks any written discharge procedures. Finally, Buffalo Psychiatric Center's Strozzi TPP lacks due process procedures.

[14] 14 NYCRR 595.9

[15] Involuntary discharges fall into several categories requiring due process. These include residents who have vacated without explanation, residents requiring hospitalization, residents whose behavior poses a threat to self or others and residents whose actions are disruptive to the program, among others.

Notably, none of the 12 facilities specifically require review and pre-approval of discharges by management level staff. Although such review and pre-approval are not required by regulation, these steps have been implemented at Kingsboro PC as a result of CQC's review of the improper discharge of a resident and should be considered to enhance discharge protocols.

FINDINGS/RECOMMENDATIONS

The Inspector General determined that Kingsboro PC failed to implement its new discharge plan policy from September 2010 to April 2011, which required both the Director of Social Work and Chief of Community Services to review and approve all upcoming discharge plans. Additionally, the Inspector General found that Executive Director James McCummings, failed to ensure the new policy to address obvious deficiencies in the discharge process was instituted, despite assuring CQC otherwise in September 2010. Considering Kingsboro PC staff's egregious acts surrounding the April 2010 improper discharge, which warranted immediate corrective measures, McCummings's failure to ensure implementation of such measures is inexcusable. Given the Director of Social Work's statement that she was not instructed either to attend discharge meetings or to participate in a review of discharge plans, it is clear that the required review and approval of discharge plans did not occur in every instance.

The Inspector General also found that then Acting Deputy Director of Program Operations Tanya Priester, when unexpectedly pressed by CQC to provide the completed forms documenting discharge plan review and approval, orchestrated a deliberate plan of deception. In April 2011, Priester compelled subordinate staff to sign discharge plans to create the false appearance that they had reviewed and approved the plans at earlier dates. Further, the Inspector General concluded that Priester, while under oath, testified untruthfully to the Inspector General during this investigation. The Inspector General recommends that OMH immediately review all Kingsboro PC Mary Brooks TLR discharge plans completed during the period at issue to ensure plans were appropriate.

The Inspector General notes that in October 2011, in light of CQC's findings, OMH removed Priester from the title of Acting Deputy Director of Program Operations and placed her in a Treatment Team Leader title, pending the outcome of the Inspector General's investigation. The Inspector General recommends that OMH discipline Priester and other Kingsboro PC officials as appropriate. The Inspector General will also provide these findings to the Kings County District Attorney.

This report will be provided to the New York State Joint Commission on Public Ethics as Priester's actions may constitute a violation of New York State Public Officers law.

The Inspector General also found that discharge procedures at a number of OMH facilities are deficient and fail to meet the requirements of relevant OMH regulations. The Inspector General recommends that OMH promulgate uniform discharge policies for all TLRs and TPPs which comply with regulations and include a verifiable review and pre-approval by

management of all discharges. OMH also should conduct periodic audits to ensure facility compliance with the new policy.

RESPONSE BY THE OFFICE OF MENTAL HEALTH

The Inspector General advised OMH of the findings and recommendations herein. In response to this report, OMH is reviewing for implementation the Inspector General's recommendations with respect to discharge policies for residents of Transitional Living Residences and Transitional Placement Programs. The recommendations regarding discharge plans for residents of the Mary Brooks TLR have been forwarded to Kingsboro PC management for appropriate implementation. OMH will advise the Inspector General within ninety days of the outcome of said review and implementation.

Further, OMH has taken disciplinary action against Priester and other Kingsboro PC officials.