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]

[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] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed physical abuse and abuse (deliberate inappropriate use of restraints).

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: September 26, 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

Adjud. Case #: [redacted]

Before: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
Administrative Hearings Unit
1200 East and West Road
West Seneca, New York 14224
On: [redacted]

Parties: 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
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By: Theresa Wells, Esq.

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse. 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 abuse 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 physical abuse and/or abuse (deliberate inappropriate use of restraints) when you conducted a restraint with excessive force and improper technique, which included grabbing a service recipient and falling to the floor, causing him to sustain abrasions and a contusion to his foot.
>
> These allegations have been SUBSTANTIATED as Category 3 physical abuse and Category 3 abuse (deliberate inappropriate use of restraints) 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 [redacted] facility is located at [redacted] The facility is operated by [redacted]

[redacted] and is certified by the New York State Office for People With Developmental Disabilities (OPWDD), a facility or provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of Investigator [redacted] [redacted] Quality Assurance (QA) Specialist and Justice Center Exhibit 6)

5. At the time of the alleged abuse, the Subject had been employed by [redacted] at the [redacted] facility for more than four years. On [redacted] the Subject worked the 8:30 a.m. to 4:30 p.m. shift and was assigned to supervise four other service recipients. The Subject's job title was [redacted] Instructor, although he worked in the capacity of a Direct Support Professional (DSP). The Subject was trained in Strategies for Crisis Intervention and Prevention Revised (SCIP-R) and completed his SCIP-R re-certification refresher class on [redacted]. The Subject was a custodian as that term is so defined in SSL § 488 (2).

6. At the time of the alleged abuse, the Service Recipient was a thirty year old ambulatory male who was approximately five feet seven inches in height and weighed approximately two-hundred and forty pounds. The Service Recipient wore glasses and was diagnosed with a profound hearing loss/deafness and communicated by using American Sign Language (ALS). The Service Recipient could also read lips, as well as read the written word and body language to some degree. Usually from approximately 9:30 a.m. until 2:30 p.m., the Service Recipient daily attended the [redacted] program at the facility. The Service Recipient had other diagnoses of Osteopenia (early bone loss), Mild Intellectual Disability, Intermittent Explosive Disorder, Obsessive Compulsive Disorder, Attention Deficit Hyperactive Disorder, self-injurious behaviors (SIB), Epilepsy and other medical conditions. He also enjoys drinking coffee and being in control of the coffee. (Hearing testimonies of the Subject, Investigator [redacted], [redacted]/QA Specialist; and Justice Center Exhibits 6 and 18)

7. The Service Recipient's Individual Protection Plan - Day Program Safeguard (DPS) required his staff supervisory levels to be "range of scan" and further noted that he had a history of exhibiting difficult behaviors, such as aggression, non-compliance with verbal requests, property destruction, self-injurious behaviors such as hitting, biting himself, pulling his own hair and other behaviors. The Service Recipient's DPS plan further mandated that, due to his Osteopenia, authorized PRN medications, discussed in detail below, should be used in dealing with a behavioral crisis and that SCIP-R physical interventions should only be performed in the event of an emergency. OPWDD's policy required that physical interventions only be used as a last resort. (Hearing testimonies of the Subject, Investigator [redacted], [redacted] QA Specialist; Justice Center Exhibits 17 at page 3 and 20)

8. The Service Recipient's Behavior Support Plan (BSP) stated that he was prone to behaviors in a "cluster" with a "rapid sequence" and that the display of one of the various behaviors is a warning sign of an impending rapid sequence of behaviors. The Service Recipient's BSP further listed as warning signs the display of behaviors, such as slamming doors, screaming, pounding on objects, head butting, physical aggression, self-injurious behaviors, property destruction, glaring at someone and avoiding eye contact and other noted behaviors. The BSP further mandated many reactive strategies for staff to follow to include, but is not limited, to strategies such as attempting to gain eye contact with the Service Recipient to sign to him to stop, to rest or to communicate to him that everything is fine. The BSP also suggested that staff give the Service Recipient some space to calm down because he will become more aggressive if anyone comes closer to him. Additionally, the BSP stated that after [redacted] staff has attempted to use coping skills with the Service Recipient for a minimum of ten minutes and the Service Recipient shows no signs of calming, then he can be offered an approved PRN or anti-anxiety

medication, such as Ativan and Haldol that is administered at program. The PRN medication is designed to reduce the Service Recipient's anxiety and assist in the de-escalation process. (Justice Center Exhibits 6 and 18 or BSP "Quick Look" cover sheet and Justice Center Exhibit 19, page 2)

9. On the morning of [redacted], the Subject was assigned with other staff to retrieve the Service Recipient from his group home residence to transport him to the [redacted] facility. At the time of pick up, the group home staff informed facility-transporting staff that the Service Recipient had been agitated that morning. The Service Recipient was then transported to the facility's [redacted] program, arriving at approximately 10:00 a.m. (Hearing testimony of the Subject)

10. Sometime after 10:00 a.m. on August 25th, Staff Member D who was in the kitchen observed the Service Recipient pour all of the coffee creamer into his own cup. Staff Member D used sign language to tell the Service Recipient "no" and that he could not do this. Service Recipient then snatched the coffee creamer away from Staff Member D who then saw indications that the Service Recipient was becoming agitated. Staff Member D escorted the other service recipients out of the kitchen area. Staff Member A was still present in the kitchen and moved near the sink to be closer to the situation. The Service Recipient began to stare at Staff Member A and then started to kick the dishwasher. (Justice Center Exhibits 6, 9 and 16)

11. At approximately 10:30 a.m., the Subject was walking past the kitchen when he heard banging, screaming and what he later learned was the sound of the dishwasher being kicked. He entered the kitchen where he saw the Service Recipient in an "extremely agitated state." Staff Member A was still in the kitchen at the time. The Subject then asked the Service Recipient in sign language what happened. The Service Recipient signed back to the Subject that he was mad about the coffee creamer. Staff Member A told the Subject his version of what had happened.

Using sign language, the Subject told the Service Recipient "no," then told him that it was not okay to steal coffee creamer. The Service Recipient continued to act out and displayed "clusters" of escalating behaviors in a "rapid sequence." (Justice Center Exhibits 18, pages 4-6 and 19) The Subject attempted to sign to the Service Recipient to relax and calm down. However, the Service Recipient would not have eye contact with the Subject. (Justice Center Exhibit 18, page 2) The Service Recipient positioned himself in between the table, the wall and the refrigerator. The Service Recipient banged his head on the refrigerator, threw the refrigerator doors open, bit himself on the arms and tipped and/or shook the refrigerator back and forth. (Hearing testimony of the Subject; Justice Center Exhibits 6, 8-10, 13 - 16 and 18-19)

12. While the Subject and Staff Member A were in the kitchen, Staff Member B entered when the Service Recipient was biting his arm. Staff Member C, the Subject's supervisor, then entered the kitchen. He told staff to prevent the Service Recipient from biting himself. At some point, the Subject told staff to initiate a SCIP-R technique known as a two-person take down of the Service Recipient to a three-person supine position. The Subject was standing to one side of the Service Recipient. The Service Recipient was standing in front of the refrigerator trying to hold, shake and tip the refrigerator. The Subject then used his left hand and stabilized the appliance in place. Thereafter, the Subject attempted to initiate the SCIP-R two-person take down restraint maneuver by using his right hand to grab the Service Recipient's arm to pull or push the Service Recipient back, then attempted to put his arm against the Service Recipient's shoulder. All the while, Staff Member A unsuccessfully tried to find, then secure, the Service Recipient's other arm and avoid being kicked. Staff Member B successfully secured the Service Recipient's leg and held onto it. The Service Recipient lost his balance. He and the Subject then fell to the floor.

13. The Service Recipient was biting, kicking and thrashing about the floor as the

Subject and Staff Member A continued their restraint hold of the Service Recipient's wrist/arms. Staff released their restraint holds after the Service Recipient rolled onto his stomach. Staff Member C then left the kitchen and summoned the nurse to the kitchen. At approximately 10:49 a.m., the nurse arrived then administered the PRN medication known as Ativan and Haldol to the Service Recipient. (Justice Center Exhibits 6, page 7-8, 12; Justice Center Exhibit 18, pages 6-7; and Justice Center Exhibit 19, page 2)

14. During the physical altercation, the Service Recipient's shirt sleeve was ripped and the Service Recipient sustained a bloody nose, abrasions to his face, neck and upper limb and a foot contusion. He also had a mark on his forehead and bite mark on his wrist which broke through the skin. Thereafter, he was taken to the hospital for evaluation. (Hearing testimonies of the Subject and Investigator [redacted], [redacted] QA Specialist and Justice Center Exhibits 6-10, 12-14 and 19)

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 abuse and 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 abuse of a person in a facility or provider agency is defined by SSL §§ 488(1)(a) and (d) which states as follows:

> "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.
>
> "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

Substantiated reports of abuse shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined under SSL § 493(4)(c) as follows:

> 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(s) committed the act or acts of abuse alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse, 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 cited in the substantiated report constitutes the category of abuse as set forth in the substantiated report.

If the Justice Center did not prove the abuse 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 acts, described as "Allegation 1" in the substantiated report dated [redacted]

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-21) As a part of the investigation, the Service Recipient was interviewed on September 11, 2014 and provided a written statement, which was admitted into evidence as Justice Center Exhibit 10.

In his written statement, the Service Recipient stated that staff "hurt" him that day and that he "felt hurt inside," that staff "stole" his coffee and told him to "calm down." The Service Recipient further stated that he did not try to "tip the fridge over" and that he was offered then took his PRN medications. (Justice Center Exhibits 6, page 8 and 10) The investigation underlying the substantiated report was conducted by Investigator [redacted] [redacted]/QA Specialist, who prepared the report that was entered into evidence as Justice Center's Exhibit 6.[1] Investigator [redacted] was the only witness to testify at the hearing on behalf of the Justice Center.

The Subject testified on his own behalf and provided Subject's Exhibit A as his only

[1] Investigator [redacted], [redacted] QA Specialist testified as to an inadvertent error. She stated that the Subject was incorrectly identified on page 4 of her report as an individual and not as a staff person. (Justice Center Exhibit 6)

documentary evidence. Subject's Exhibit A is an internal memorandum dated [redacted] from [redacted], QA Coordinator at [redacted], which memorandum concluded by not substantiating physical abuse in this situation. The [redacted] memorandum differed from the Justice Center's substantiated findings of abuse.

During his interrogation and testimony, the Subject maintained that, in responding to the Service Recipient's behavioral episode, it was his intent to protect the Service Recipient and commence the SCIP-R maneuver known as a two-person take down of the Service Recipient leading to a three-person supine position. (Justice Center Exhibit 20, Unit 5.2 entitled Core Techniques at pages 106-110) The Subject further explained that, during the behavioral episode, the Service Recipient was standing in front of the refrigerator tipping it from side to side. The Subject stated that he stabilized the refrigerator with one hand, then used his other hand to secure the Service Recipient's arm to prevent the appliance from falling on the Service Recipient. Yet, it is clear from the proof that at the time the Subject secured the Service Recipient's arm, the refrigerator was stabilized and no longer posed a danger to the Service Recipient. Furthermore, when the Subject secured the Service Recipient's arm, he was aware of the Service Recipient's Osteopenia, yet intended to proceed with the SCIP-R maneuver that he mistakenly thought had been authorized in the Service Recipient's plans. The Subject further testified that now he knows that the SCIP-R maneuver was not authorized in the Service Recipient's plan unless it was performed on an emergency basis. (Justice Center Exhibit 17, page 3 of Service Recipient's DPS) Moreover, during the SCIP-R intervention, the Subject and the Service Recipient fell to the floor and the Subject continued to hold the Service Recipient's wrist/arm until the Service Recipient rolled onto his stomach. (Hearing testimony of the Subject, Justice Center Exhibits 6, 8-9, 13-14, 17-20)

Investigator [redacted], [redacted] QA Specialist, testified that OPWDD's policy is that a physical intervention (SCIP-R) should be used only as a last resort. Referencing OPWDD's policy on the emergency use of restraints, she stated that the use of such restraints was not necessary here and that the Subject had other options available to him to de-escalate the situation. She indicated that the Subject could have used verbal and non-verbal calming techniques, as well as a PRN medication, in order to quell the situation. She further stated that the use of PRN medication is preferred over the use of physical interventions because of the risks of harm associated with using physical restraints.

Investigator [redacted] testimony is credited evidence. It is determined that the record supports that the Service Recipient's behavioral episode did not constitute an emergency situation simply because he was demonstrating typical aggressive target behaviors. There were specific reactive strategies staff were required to use to address the Service Recipient behaviors and to keep him and others safe from harm. Staff had removed the other service recipients from the kitchen, moved the tables that the Service Recipient was banging on and stabilized the tipping refrigerator. Although the Service Recipient was trying to bite himself and kick staff who were able to move out of harm's way, the record supports that the Service Recipient was not in peril and was safe. Clearly, in this case, any risk of harm associated with offering and administering the PRN medications to the Service Recipient as his BSP required was far less than engaging in the SCIP-R physical intervention to try to control the situation. Therefore, the Subject should have been provided PRN medications (Ativan and Haldol) earlier during the course of the incident to assist the Service Recipient in the de-escalation of his behaviors. According to the Service Recipient's BSP, when the Service Recipient is engaging in self-injurious behaviors (SIB) and property destruction behaviors, he should be offered the PRN medication once certain criteria were met.

The specific criteria, set forth in the Service Recipient's BSP, were met. The Subject was aware that the Service Recipient was in an agitated state before he even came to program that morning. The Service Recipient was displaying the target behavioral warning signs, such as screaming, slamming doors, physical aggression, SIB behaviors and property destruction. Moreover, [redacted] staff had tried to encourage coping skills for a minimum of ten minutes during the on-going behavioral episode, but the Service Recipient showed no meaningful signs of calming.

Additionally, there were many other reactive strategies listed in the Service Recipient's BSP that the Subject could have initiated prior to using physical contact, but he failed to do so. The Subject could have removed the coffee creamer, a target of the Service Recipient's concern, and then try to re-direct him and continue with verbal/non-verbal calming techniques, or even demonstrating the taking of deep breaths. The Subject could have asked the Service Recipient if he wanted to go to a more tranquil room to re-gain control. During the earlier phases of the incident, staff kept moving closer to the Service Recipient, which according to his BSP, may trigger agitation and misbehaviors. The Subject could have provided the Service Recipient with more space to try to de-escalate, but he did not. (Justice Center Exhibit 18)

Physical Abuse

During a behavioral incident, the Subject committed physical abuse when he secured the Service Recipient's arm and pushed or pulled the Service Recipient back causing him to lose his balance and fall to the floor. While on the floor, the Subject continued his hold of the Service Recipient's wrist/arm. As a result of the Subject's actions, the Service Recipient sustained physical injuries.

Here, the Subject knew of the Service Recipient's Osteopenia condition, which increased the risk of injury of the Service Recipient in the event of a physical intervention during a behavioral

episode. The record supports that the Subject did not provide the Service Recipient with sufficient time to de-escalate and the Subject acted recklessly by commencing a physical SCIP-R maneuver. Given the circumstances, the Subject's actions were undertaken in conscious disregard of a substantial and unjustifiable risk of harm or injury to the Service Recipient. As previously mentioned, the Subject's physical contact with the Service Recipient was unwarranted as an emergency measure because it was initiated after the danger of the tipping refrigerator had been resolved.

At the hearing, the Subject raises many claims, all of which lacked merit or were sufficient. He also introduced into evidence, as Subject's A Exhibit 22 (a Community Services' internal memorandum dated [redacted] from [redacted], QA Coordinator), that unsubstantiated the incident as physical abuse only, without determining whether the Subject's conduct was reckless and without addressing the issue of the deliberate inappropriate use of restraints. The said Community Services' letter further indicated that the Subject did not follow the BSP as written because he did not attempt to de-escalate the Service Recipient's behavior by modeling deep breathing and signing to the Service Recipient the word "rest." The said memorandum concluded that the incident involving the Subject was unsubstantiated because Community Services found that the Subject did not intend to harm the Service Recipient and that all direct witnesses indicated that the situation could not have been handled in a different manner.

Although the record supports that the Subject did not intend to harm the Service Recipient, under SSL § 488(1)(a), a custodian may be responsible for committing physical abuse by acting in a "reckless" manner. Under SSL § 488(16), the definition of "recklessly" is that definition as set forth in Penal Law. Penal Law § 15.05(3) states in relevant part that a "…person acts recklessly with respect to a result or to a circumstance described by a statute defining an offense when he is

aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists…." In this case, the Subject was aware of the Service Recipient's Osteopenia condition that increases the Service Recipient's risk of injury in the event of a physical intervention. Regardless, the Subject proceeded to commence a physical restraint upon the Service Recipient who sustained physical injuries when he fell to the floor. Secondly, a decision by the Community Services, a private, non-governmental agency, is not binding upon the Justice Center.

As such, it is determined that the Subject was a custodian and that in accordance with SSL § 488(1)(a) his physical contact with the Service Recipient was recklessly undertaken with a conscious disregard of a substantial and unjustifiable risk of injury or harm. The Subject's actions caused the physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient or caused the likelihood of such injury or impairment.

Abuse (Deliberate Inappropriate Use of Restraints)

The evidence here supports that the Subject knew of the Service Recipient's Osteopenia condition. The Subject was not warranted in initiating a restraint because the situation with the refrigerator was stabilized. Additionally, a restraint was not authorized unless all attempts at de-escalation have failed. The Subject, as a custodian, purposely initiated a SCIP-R restraint by securing the Service Recipient's arm then pushed or pulled him back. This securing of the arm constituted a restraint. The Subject used the grip of his hand as a manual measure to immobilize or limit the Service Recipient's ability to move his arms, legs or body freely and this constituted a restraint. The Subject continued his restraint hold of the Service Recipient even after they both fell to the floor. The Subject's physical contact or restraint was unauthorized, unnecessary and deliberately inconsistent with the Service Recipient's BSP and DPS plans that disallowed SCIP-R physical interventions, OPWDD's policies and any prescribed training of the provider agency.

(Hearing testimonies of the Subject, Investigator [redacted] [redacted]/QA Specialist; Justice Center Exhibits 6, 17-18 and 20-21)

The Subject argued that his physical contact with the Service Recipient was justified under the emergency exception of SSL §488(1)(d) and that all of the Service Recipient's plans allow for the use of emergency SCIP-R in the event that the Service Recipient was engaging in property destruction and self-injurious behaviors. (Justice Center Exhibits 17-18)

However, there was no emergency here that warranted a physical intervention as previously discussed in detail. The Subject's actions were unjustified as emergency measures. The Subject also had other reactive measures specified in the Service Recipient's BSP that he could have pursued, such as offering a PRN medication when the Service Recipient exhibited such behaviors. The unauthorized restraint was used in a manner that was deliberately inconsistent with the Service Recipient's BSP and DPS, as well as OPWDD's policies. It is further determined that the restraint was not a reasonable emergency intervention to prevent an imminent risk of harm under these circumstances.

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 physical abuse and abuse (deliberate inappropriate use of restraints) as alleged. The substantiated report will not be amended or sealed.

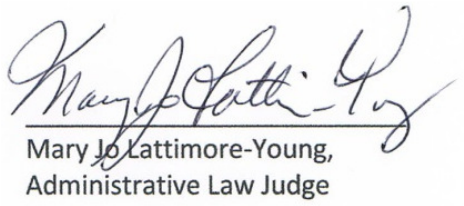
Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as Category 3 acts.

DECISION: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed physical abused and abuse (deliberate inappropriate use of restraints).

The substantiated report is properly categorized as a Category 3 act.

This decision is recommended by Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: September 19, 2016
West Seneca, New York



Mary Jo Lattimore-Young,
Administrative Law Judge