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: Laurie Cummings, Esq.

[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] of abuse (obstruction of reports of reportable incidents) and neglect (Allegation 1), neglect (Allegation 2), and abuse (deliberate inappropriate use of restraints) and neglect (Allegation 3) by the Subject of a Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (obstruction of reports of reportable incidents) and neglect, neglect and abuse (deliberate inappropriate use of restraints) and neglect.

The substantiated report is properly categorized as Category 3 conduct.

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: February 23, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

`STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjudication Case #: [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

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

Parties: Vulnerable Persons' Central Register
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: Laurie Cummings, Esq.

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] for abuse and neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a report of substantiated finding dated [redacted] of abuse (obstruction of reports of reportable incidents) and neglect in Allegation 1, neglect in Allegation 2, and abuse (deliberate inappropriate use of restraints) and neglect in Allegation 3, by the Subject of a Service Recipient.

2. The Justice Center's substantiated report against the Subject concluded that:

Allegation 1

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (obstruction of reports of reportable incidents) and/or neglect when you failed to properly report the physical intervention used on the service recipient to your supervisor and/or management and/or the psychologist.

This allegation has been SUBSTANTIATED as Category 3 abuse (obstruction of reports of reportable incidents) and Category 3 neglect pursuant to Social Services Law § 493(4)(c).

Allegation 2

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to secure a medical or nursing evaluation after performing a physical intervention on the service recipient.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

Allegation 3

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) and/or neglect when you conducted a restraint with improper technique, which included restraining the service recipient on his side on a couch.

This allegation has been SUBSTANTIATED as Category 3 abuse (deliberate inappropriate use of restraints) and Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

4. The facility, located at [redacted], is an [redacted], which provides residential services for up to eight males, and is operated by [redacted]. [redacted] is a non-profit corporation that is certified by the New York State Office for People With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted] and Justice Center Exhibit 7)

5. At the time of the alleged abuse and neglect, the Service Recipient, who had resided at the facility for four months, was a relatively high functioning and expressive twenty-two year old male with diagnoses of pervasive developmental disorder, moderate mood disorder, psychosis and attention deficit hyperactivity disorder. The Service Recipient also had a history of suicidal thoughts and psychiatric hallucinations. (Justice Center Exhibit 9) The Service Recipient required a CPAP machine for a condition related to breathing difficulties. (Justice Center Exhibit 13)

6. At the time of the alleged abuse and neglect, the Subject had been employed as a Direct Support Professional (DSP) at the facility for one year. (Hearing testimony of the Subject) The Subject was a custodian and a mandated reporter as the terms are so defined in SSL § 488(2) and (5).

7. At the time of the alleged abuse and neglect, the facility employed the program Strategies for Crisis Intervention Prevention (SCIP) to address service recipients' behaviors. The SCIP program prescribed techniques of verbal redirection and counselling to encourage de-escalation and to prevent physical confrontations. The SCIP program also mandated that the least invasive and safest approaches be used when physical intervention was required and provided trainings and techniques in authorized physical interventions. At that time, the Subject was trained and certified in SCIP. (Hearing testimony of [redacted])

8. At the time of the alleged abuse and neglect, facility policy and practice required that when a staff employed any type of physical intervention on a service recipient, that staff was required to complete and submit an "ABC" Reporting Form, which was a record of the service recipient's behavior and the staff's intervention. Facility policy and practice also required that staff notify facility administration and ensure that the service recipient receive a medical or nursing evaluation, which would include a body check, to ascertain whether the service recipient had sustained any injuries as a result of the physical intervention. (Hearing testimony of [redacted])

9. At the time of the alleged abuse and neglect, the Service Recipient's Behavior Support Plan (BSP) indicated that specific SCIP techniques could be used if all reactive strategies failed to promote positive behaviors and that the SCIP approved moves for the Service Recipient

were up to and including a Standing Wrap. (Justice Center Exhibit 9) At that time, the Subject was familiar with the Service Recipient's BSP. (Hearing testimony of the Subject)

10. On [redacted], at approximately 4:00 p.m., the Service Recipient returned to the facility from his day habilitation program and, as was his usual routine, he went to the second floor common room of the facility to take a snack from the cupboard. Upon discovering that the snack that he wanted was not there, the Service Recipient complained and DSP 1, who was present, suggested that he go downstairs to the kitchen. (Justice Center Exhibit 11)

11. The Service Recipient found the Subject in the kitchen preparing dinner for the service recipients. In response to the Service Recipient's complaint about the lack of a snack, the Subject gave the Service Recipient the choice of either waiting for dinner to be ready or making a sandwich for himself. (Justice Center Exhibit 10)

12. Unappeased, the Service Recipient returned upstairs, where DSP 1 was working. In reaction to a behavior exhibited by the Service Recipient, DSP 1 executed an improper physical intervention, the noise from which drew the Subject upstairs. (Hearing testimony of the Subject and Justice Center Exhibit 10)

13. Upon entering the upstairs common room, the Subject observed the Service Recipient in a horizontal, sideways position on the couch while being held down from above by DSP 1. (Justice Center Exhibit 13) The physical intervention utilized by DSP 1, and observed by the Subject, limited the ability of the Service Recipient to freely move his body and was deliberately inconsistent with the Service Recipient's BSP and SCIP sanctioned techniques, which prohibited the physical restraint of the Service Recipient in a seated or laying position. (Justice Center Exhibit 9 and hearing testimony of [redacted])

14. The Subject approached the two and, perceiving that the Service Recipient was kicking his legs toward a nearby table, held the Service Recipient's legs down. (Hearing testimony of the Subject) The physical intervention utilized by the Subject limited the ability of the Service Recipient to freely move his legs. (Justice Center Exhibit 9 and hearing testimony of [redacted])

15. While DSP 1 was holding the Service Recipient down in a horizontal position on the couch and the Subject was holding his legs, the Service Recipient complained that he could not breathe. (Hearing testimony of the Subject and Justice Center Exhibits 6, 10, and 11)

16. The Subject and DSP 1 released the Service Recipient, and the Subject told DSP 1 to leave the Service Recipient with him. The Service Recipient was calmed thereafter by the Subject. (Hearing testimony of the Subject)

17. After the incident, DSP 1 completed an "ABC" Reporting Form, which omitted the fact that he had used a physical intervention on the Service Recipient or that the Service Recipient had complained of difficulty breathing during the intervention. (Justice Center Exhibit 8)

18. After the incident, the Subject telephoned the facility Assistant Manager on duty and reported to him that the Service Recipient had had a behavior and that staff had verbally calmed him down. The Subject did not disclose that there had been a physical intervention or that the Service Recipient had complained of difficulty breathing during the intervention. (Justice Center Exhibit 12)

19. After the incident, the Subject did not notify the facility medical and/or nursing staff of the physical intervention, nor did he ensure that the Service Recipient received a medical or nursing evaluation. (Hearing testimony of the Subject)

20. The Subject did not report the reportable incident that he observed and participated

in to the Vulnerable Persons' Central Register immediately upon discovery or at any time.

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the acts giving rise to the substantiated reports.
- 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 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 and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1) to include the following:

> (d) "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.
>
> (f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the

> treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.
>
> (h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient.

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

> (c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of abuse and/or neglect alleged in the substantiated report that are the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged abuse and/or neglect in a report, 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 acts of abuse and/or neglect cited in the substantiated report constitute the category of abuse and/or neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed the acts described as Allegations 1, 2 and 3 in the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-13) The investigation underlying the substantiated report was conducted by [redacted], who testified on behalf of the Justice Center.

The Subject testified at the hearing in his own behalf.

The Incident

While there are three individual allegations, each consisting of different elements and requiring separate analyses, they all stem from the same set of facts, the basis for the finding of which is set out herein.

Some material facts were admitted by the Subject in his hearing testimony. In his testimony, the Subject acknowledged that he was trained and certified in SCIP techniques; that according to the Service Recipient's BSP, a physical restraint with the Service Recipient in a seated or lying position was not permitted; that he observed DSP 1 perform a physical intervention on the Service Recipient; that, at least for a moment, he held the Service Recipient's legs down during DSP 1's physical intervention; that he heard the Service Recipient say that he could not breathe; that he did not report to the facility Assistant Manager that the Service Recipient had been subjected to a physical intervention or that the Service Recipient had complained of difficulty breathing; and, that he did not ensure that the Service Recipient was evaluated by a doctor or nurse after the incident.

[redacted], provided

uncontradicted testimony that facility policy mandated that any physical intervention by staff on a service recipient was required to be reported to facility administration and that staff were required to ensure that the service recipient be evaluated by a medical professional, which would include a body check, to ascertain whether any physical injury had occurred as a result of the intervention.

The Subject did not dispute this testimony when cross-examined, but he did testify that when he reported the incident to the facility Assistant Manager, he omitted the details of the physical intervention and the Service Recipient's complaint of breathing difficulties during the intervention. The Subject testified that he had just given the facility Assistant Manager a brief report, that a full report, which would presumably include the omitted information, would be communicated in DSP 1's "ABC" Reporting Form (Justice Center Exhibit 8) and that the facility Assistant Manager would thereafter determine whether a medical evaluation was necessary. This aspect of the Subject's testimony was not credited. It is clear that the Subject was simply attempting to shift responsibility regarding the Service Recipient's medical evaluation onto the facility Assistant Manager, to whom he had not disclosed that a physical intervention had even occurred. In any case, [redacted] testimony, that staff must notify administration of any physical intervention and that staff must also seek medical attention for the service recipient involved, was credible and logical evidence and is, therefore, accepted as such.

The primary question of fact remaining is whether the Subject observed DSP 1 commit an improper unauthorized physical restraint on the Service Recipient. With respect to this question, the Justice Center relied primarily on [redacted] interview of the Service Recipient, his [redacted] interview of service recipient 1, his [redacted] interrogation of the Subject and the written statement of

DSP 1 dated [redacted].

The Service Recipient's evidence was memorialized by [redacted] in handwritten notes, which were taken during the interview (Justice Center Exhibit 13), and summarized in the Investigative Report (Justice Center Exhibit 6). During the interview, the Service Recipient disclosed that when he became upset about the lack of a snack, DSP 1 "wrapped" him and "put" him on the couch, and that he had fallen to the floor at one point during the struggle. The Service Recipient indicated that he experienced difficulty breathing because DSP 1 was "on top of him" when he was on the couch. The Service Recipient also indicated that, because he generally had difficulty breathing, he used a CPAP machine, and that as a result of the incident, his back was hurting, which he was able to relieve with a shower.

The Service Recipient also stated that the Subject "was helping - trying to get [DSP 1] to stop" and that he said that, after the incident, he "wanted to call police to lock them up." (Justice Center Exhibit 13) This evidence primarily discloses that the Subject was present and observed when DSP 1 subjected the Service Recipient to an improper unauthorized physical restraint.

Service recipient 1 was the only person, other than the Subject, who witnessed DSP 1's physical intervention. Service recipient 1's evidence was memorialized in handwritten notes, which were taken during the interview (Justice Center Exhibit 13), and summarized in the Investigative Report (Justice Center Exhibit 6). Service recipient 1 indicated that he saw DSP 1 hold the Service Recipient against the wall, that he saw the Service Recipient lying on the couch "on the bottom" and that the Service Recipient said "I can't breathe." (Justice Center Exhibit 6) Service recipient 1 also stated that he saw the Subject, that the Subject helped and that he did not see anything further. (Justice Center Exhibit 13) This credible evidence corroborates the Service

Recipient's statement that the Subject was present when DSP 1 subjected the Service Recipient to an improper unauthorized physical restraint.

The Subject provided four accounts of the relevant events. The Subject was interrogated by [redacted] on [redacted], and told him that, when he entered the common room, he observed both the Service Recipient and DSP 1 on the couch, that the Service Recipient was on his side, lying on the couch, that he held the Service Recipient's legs while trying to move the table away and that DSP 1 released the Service Recipient when the Service Recipient said that he was having trouble breathing. The Subject denied that DSP 1 had been on top of the Service Recipient. (Justice Center Exhibit 6)

The only further information provided in the Subject's written and signed statement dated [redacted] (Justice Center Exhibit 10) was that, at the relevant time, the Subject observed DSP 1 to be holding the Service Recipient's hands and that the Service Recipient was agitated.

The Subject's Request for Amendment of Substantiated Report dated [redacted] (Justice Center Exhibit 2) indicates that, at the relevant time, the Subject observed DSP 1 "apparently holding firmly a resident's hand while both were sitting on the couch as the latter attempted to free his hand." The Subject also indicated that, as the incident "appeared unusual" to him, he immediately alerted the facility Assistant Manager and instructed DSP 1 to complete the "ABC" Reporting Form.

With respect to the question of what he had observed, the Subject's testimony deviated from his previous statements. The Subject testified that when he entered the common room, he observed the Service Recipient sitting on the couch alone with DSP 1 standing in front of him, holding onto his wrists. The Subject testified that because the Service Recipient was agitated and

kicking his legs, he held the Service Recipient's legs down with his left forearm, pushed the coffee table aside with his right hand and sat down beside him. The Subject testified that he then told DSP 1 to leave the Service Recipient with him, which he did, that he telephoned the facility Assistant Manager on duty and told him that the Service Recipient had had a behavior, but that he had calmed him down, and that he kept the Service Recipient with him for the rest of his shift.

In his testimony, the Subject denied that DSP 1 had been on the couch with the Service Recipient. In his testimony, the Subject explained that, while his own involvement may have constituted a physical intervention, it was only to prevent injury to the Service Recipient and that he did not have the Service Recipient checked by a doctor or nurse because he had not detected any injury to the Service Recipient and that the facility Assistant Manager would arrange for the medical evaluation, if it were deemed necessary.

Given the corroborating statements of the Service Recipient and service recipient 1, the unanimous evidence that the Service Recipient complained that he had trouble breathing, the Subject's failure to disclose the Service Recipient's complaint to the facility Assistant Manager, and the Subject's inconsistent versions of DSP 1's physical intervention, it is found that the Subject's denial that he witnessed DSP 1 execute an improper unauthorized physical restraint on the Service Recipient, is not credited evidence.

Having accepted the facts admitted by the Subject and the facts that were otherwise established, the next question is whether, based on those facts, the Subject's conduct constituted the acts of abuse and neglect, as alleged.

Allegation 1: Abuse (Obstruction of Reports of Reportable Incidents)

In this case, the allegation of obstruction of reports of reportable incidents was that the Subject failed to properly report the physical intervention used on the Service Recipient to his

supervisor and/or management and/or the psychologist. A failure to report a reportable incident is established when a preponderance of the evidence shows that the Subject was a custodian, and therefore a mandated reporter, and that the Subject failed to report a reportable incident upon discovery. Here, the Subject was a custodian and mandated reporter and, in that capacity, he witnessed DSP 1 commit an unauthorized inappropriate physical intervention on the Service Recipient. However, the Subject did not immediately report the suspected reportable incident upon discovery, or at any time, to the Justice Center or to anyone else. A preponderance of the evidence establishes that the Subject committed abuse (obstruction of reports of reportable incidents) by failing to report a suspected reportable incident immediately upon his discovery of the incident.

Allegation 1: Neglect

Allegation 1 also includes a charge of neglect against the Subject for failing to properly report the physical intervention used on the Service Recipient to the facility Assistant Manager or to any other facility authority. One of the Subject's duties was to comply with the facility policies and practices by notifying facility administration whenever a physical intervention was executed by staff to manage a service recipient's behavior. The Subject breached his duty to the Service Recipient by failing to notify the facility Assistant Manager or anyone else that a physical intervention had been executed on the Service Recipient. As a result of the physical intervention, the Service Recipient, who had a preexisting breathing condition, had complained of difficulty breathing and suffered back pain. Accordingly, the Subject's breach of duty resulted in or was likely to result in physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional condition. A preponderance of the evidence establishes that the Subject committed neglect by failing to properly report the physical intervention used on the

Service Recipient to the facility Assistant Manager.

Allegation 2: Neglect

Allegation 2 is a charge of neglect against the Subject for failing to secure a medical or nursing evaluation after performing a physical intervention on the Service Recipient. One of the Subject's duties was to comply with the facility policies and practices by ensuring that service recipients receive a medical or nursing evaluation, which would include a body check, to ascertain whether there were injuries, whenever a physical intervention was executed by staff to manage behavior.

The Subject breached his duty to the Service Recipient by failing to ensure that the Service Recipient received a medical or nursing evaluation after the physical intervention. As a result of the Subject's breach of this duty, the Service Recipient, who had a preexisting breathing condition and had complained of difficulty breathing and suffered back pain, was not provided with the necessary medical evaluation and physical body check. Accordingly, the Subject's breach of duty resulted in or was likely to result in physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional condition. A preponderance of the evidence establishes that, after a physical intervention was executed on the Service Recipient, the Subject committed neglect by failing to secure a medical or nursing evaluation for him.

Allegation 3: Abuse (Deliberate Inappropriate Use of Restraints)

The Subject's conduct of holding down the Service Recipient's legs constituted a restraint as it was a manual measure used to limit his ability to freely move his legs. The Subject testified that he knew that he was using a physical intervention that was not prescribed by SCIP and was not consistent with the Service Recipient's BSP. Accordingly, the physical intervention did constitute a deliberate inappropriate use of restraints. Furthermore, there was no evidence that

that the Subject's conduct was justified as a reasonable emergency intervention to prevent imminent risk of harm to the Service Recipient or to any other person. A preponderance of the evidence establishes that the Subject committed abuse (deliberate inappropriate use of restraints).

Allegation 3: Neglect

Allegation 3 also includes a charge of neglect against the Subject for conducting a restraint with improper technique, which included restraining the Service Recipient on his side on a couch. One of the Subject's duties was to comply with SCIP training and techniques and to adhere to the Service Recipient's BSP, which stated that specific SCIP techniques could be used if all reactive strategies failed to promote positive behaviors, and that the SCIP approved moves for the Service Recipient were up to and including a Standing Wrap. (Justice Center Exhibit 9) Although there is no evidence that the Subject restrained the Service Recipient on his side, as stated above, it is found that the Subject held the Service Recipient's legs while DSP 1 performed a restraint that held the Service Recipient on his side on the couch. The Subject breached his duty to the Service Recipient by failing to follow SCIP training and techniques and by not adhering to the Service Recipient's BSP when he participated in DSP 1's physical intervention of the Service Recipient. As a result of being inappropriately restrained, the Service Recipient complained of difficulty breathing and experienced subsequent back pain. Accordingly, the Subject's breach of duty resulted in or was likely to result in physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional condition. A preponderance of the evidence establishes that the Subject committed neglect by conducting a restraint with improper technique on the Service Recipient.

Conclusion

Based on all of the evidence, it is concluded that the Justice Center has met its burden of

proving by a preponderance of the evidence that the Subject committed the acts as specified in Allegations 1, 2 and 3 of the substantiated report. The report will remain substantiated.

The next issue to be determined is whether the substantiated report constitutes the category of abuse and 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 3 act.

Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496(2). The report will be sealed after five years.

DECISION: The request of [redacted] that the substantiated report dated [redacted] of abuse (obstruction of reports of reportable incidents) and neglect (Allegation 1), neglect (Allegation 2), and abuse (deliberate inappropriate use of restraints) and neglect (Allegation 3) by the Subject of a Service Recipient be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse (obstruction of reports of reportable incidents) and neglect, neglect and abuse (deliberate inappropriate use of restraints) and neglect.

The substantiated report is properly categorized as Category 3 conduct.

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

DATED: February 13, 2017
Plainview, New York

Sharon Golish Blum, Esq.
Administrative Law Judge