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]

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 as it relates to Allegation 1 and Allegation 2. The Subject has been shown by a preponderance of the evidence to have committed physical abuse, and abuse (deliberate inappropriate use of restraints) and neglect.

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

The request of [redacted] that the substantiated report dated [redacted], be amended and sealed is granted as it relates to Allegation 3. The Subject has not been shown by a preponderance of the evidence to have committed abuse (obstruction of reports of reportable incidents).

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of these reports, as contained in the Allegation 1 and 2, for physical abuse, and abuse (deliberate inappropriate use of restraints), shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

NOW, THEREFORE, IT IS DETERMINED that the record of this report, as it pertains to Allegation 3, abuse (obstruction of reports of reportable incidents), shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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: April 6, 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

Adjud. Case #: [redacted]

Before: John T. Nasci
Administrative Law Judge

Held at: New York State Office Building
44 Hawley Street, Room 1701
Binghamton, New York 13901
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

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161 Delaware Avenue
Delmar, New York 12054-1310
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 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 "substantiated" report dated [redacted], of abuse and neglect by the Subject of a Service Recipient.

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

Allegation 1

It was alleged that on multiple unspecified dates between [redacted], and [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 an unwarranted restraint with excessive force and improper technique which included laying on top of a service recipient while in his bed, grabbing, and holding his arms, and pressing his knees into his calves causing bruising.

These allegations have been SUBSTANTIATED as Category 2 physical abuse and Category 2 abuse (deliberate inappropriate use of restraints) pursuant to Social Services Law § 493(4)(b).

Allegation 2

It was alleged that on multiple unspecified dates between [redacted], and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to

provide proper supervision, during which time you restricted a service recipients ability to move by holding him down in his bed.

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

Allegation 3

It was alleged that on multiple unspecified dates between [redacted], and [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed abuse (obstruction of reports of reportable incidents) when you failed to report and document the use of restraints on a service recipient during his bedtime.

This allegation has been SUBSTANTIATED as Category 2 abuse (obstruction of reports of reportable incidents) pursuant to Social Services Law § 493(4)(b).

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

4. The [redacted] Individualized Residential Alternative (the IRA), located at [redacted], is a group home for adults with developmental disabilities. The IRA is operated by the [redacted] which is a private agency 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], [redacted] Regional Residential Director)

5. At the time of the alleged abuse and neglect, the Subject was employed by the [redacted] as a Direct Support Professional (DSP) and had been employed by the [redacted] for approximately six months. The Subject's regular shift at the IRA was [redacted] The Subject was approximately six feet in height and weighed approximately 275 pounds. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

6. At the time of the alleged abuse and neglect, the Service Recipient was a forty-six

year old male who had been transferred to the IRA on [redacted], from a [redacted] facility. The Service Recipient's diagnoses included severe mental retardation, grand mal seizures, obsessive control disorder, and impulse control disorder. The Service Recipient's medical conditions included osteoporosis of the hips, osteoporosis of the femoral necks, osteopenia of the lumbar spine and sleep disorder. The Service Recipient had a mental age of forty-four months. (Justice Center Exhibit 34)

7. The Service Recipient had limited verbal skills and he communicated his needs through vocalizations, gestures and American Sign Language. The Service Recipient required one-on-one supervision during his waking hours, and staff were required to remain within twenty feet of him and watch him while he slept. The Service Recipient was ambulatory but required the assistance of staff using a gait belt due to the possibility of a drop seizure, which could happen at any time without any warning. The Service Recipient was approximately five feet six inches tall and weighed approximately 150 pounds. (Justice Center Exhibits 33 and 34 and Hearing testimony of [redacted], [redacted] Regional Residential Director)

8. At the time of the alleged abuse and neglect, the [redacted] had adopted, as its policy, the Strategies for Crisis Intervention and Prevention – Revised (SCIP-R) program for use within the agency. The SCIP-R program consisted of (from least restrictive to most restrictive) "Core", "Specialized" and "Restrictive" techniques for physical intervention. The [redacted] policy limited its staff to the use of only the least restrictive "Core" techniques for physical intervention and the "Specialized" technique of "Blocking Hits/Punches." The [redacted] staff's use of any other "Specialized" and "Restrictive" techniques, included in the SCIP-R program, was prohibited by [redacted] policy. [redacted] policy also provided that, in the event that a service recipient's treatment plan prescribed the use of a physical intervention technique which was not allowed by the [redacted] policy,

the use of such technique on that service recipient was limited to only emergency situations in which the safety of that service recipient was at imminent risk of harm. (Justice Center Exhibit 46 pages 83 and 84; Justice Center Exhibit 33; and Hearing testimony of [redacted], [redacted] Regional Residential Director)

9. The [redacted] policy required that, anytime physical intervention by staff with a service recipient occurred, the [redacted] staff involved in the physical intervention document the intervention on an Event To Consider (ETC) form in order to assist the treatment team in assessing trends and prescribing treatment. (Hearing testimony of [redacted], [redacted] Regional Residential Director)

10. The Service Recipient's Behavior Support Plan limited physical interventions to "a one or two person escort seated variation, arm control or arm control with assist" if the Service Recipient was seated, and "basic hug, standing wrap or 1-2 person removal ... necessary to prevent harm or damage" if the person was not seated. Because these physical interventions were not sanctioned under [redacted] policy, the use of these interventions required that the safety of the Service Recipient be at imminent risk of harm. (Justice Center Exhibit 33 and Hearing testimony of [redacted], [redacted] Regional Residential Director)

11. On [redacted], the day that the Service Recipient was transferred to the IRA from the [redacted], a [redacted] direct care staff provided the care for the Service Recipient while instructing the Subject how to perform the Service Recipient's care. Part of the Service Recipient's care was his night time routine which involved putting the Service Recipient to bed and getting him to fall asleep. The Service Recipient routinely resisted [redacted] staff's attempts to get him to sleep by making noise, squirming and getting out of bed. (Hearing testimony of the Subject)

12. The [redacted] staff instructed the Subject, while performing the same, to position the Service Recipient in bed so that he was laying on his side facing away from staff. Then the [redacted]

staff got on the bed directly behind the Service Recipient and put his leg over the Service Recipient's legs and his arms over the Service Recipient's upper body, and held him in a hug. The [redacted] staff put his body weight on him in order to counteract the Service Recipient's resistance. (Hearing testimony of the Subject)

13. The Subject cared for the Service Recipient and performed his bedtime routine, as he was instructed to do by the [redacted] staff, during most of the nights that he worked at the [redacted] between [redacted] and [redacted]. When the Subject held the Service Recipient in bed to get him to go to sleep, the Service Recipient struggled against the Subject, and the Subject sometimes applied approximately half his body weight (approximately 150 pounds) to Service Recipient to counteract the Service Recipient's struggling, which lasted ten to twenty minutes. (Hearing testimony of the Subject)

14. The Subject's technique for getting the Service Recipient to go to sleep was not authorized by [redacted]. The Subject was required to document any physical intervention, including his use of the unauthorized bedtime technique, on an ETC form. The Subject did not document any instance of his use of the unauthorized bedtime technique on the Service Recipient. (Hearing testimonies of [redacted], [redacted] Regional Residential Director and the Subject)

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 and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1)(a), (d), (f) and (h) to include:

> (a) "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.
>
> (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. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

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

> (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject committed the act or acts of abuse and/or neglect alleged in the substantiated report that is 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, 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 and/or neglect cited in the substantiated report constitutes 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 in "Allegation 1" and "Allegation 2" in the substantiated report, and has not established by a preponderance of the evidence that the Subject committed the acts described in "Allegation 3" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents and photographs obtained during the investigation. (Justice Center Exhibits 1 through 46) The investigation underlying the substantiated report was conducted by [redacted], [redacted] Regional Residential Director, who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in his own behalf and presented no other evidence.

The facts relevant to the issues in this hearing are mostly undisputed.

Allegation 1 – Physical Abuse

The Justice Center proved by a preponderance of the evidence that the Subject committed physical abuse by laying in bed with the Service Recipient, holding the Service Recipient in place in his bed with his arms and legs, and placing his body weight on top of the Service Recipient.

In order to prove physical abuse, the Justice Center must establish that the Subject intentionally or recklessly caused, by physical contact, 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. (SSL §488(1)(a)) The terms "intentionally" and "recklessly" are defined by Social Services Law as having the same meanings as provided in New York State Penal Law. (SSL §488(16)) New York State Penal Law states that "A person acts intentionally with respect to a result or to conduct described by a statute defining an offense when his conscious objective is to cause such result or to engage in such conduct." (PL §15.05(1))

The record establishes that the Subject had physical contact with the Service Recipient by laying in the Service Recipient's bed, holding the Service Recipient with his legs and arms, and using his legs, arms and body weight to hold the Service Recipient in bed. The record further establishes that it was the Subject's conscious objective to engage in such conduct, and therefore his conduct was intentional.

The record establishes that the Service Recipient was found with bruises shortly after the timeframe in question. (Justice Center Exhibits 6, 9, 40 and 42) However, there is no evidence in the record that establishes that the bruises were the result of the Subject's actions. Conversely, the evidence establishes that the Subject bruised easily from bumping into objects around the house and that the Service Recipient's bruises were likely caused in this manner. (Justice Center Exhibit 12 and Hearing testimonies of [redacted], [redacted] Regional Residential Director and the Subject) The record also reflects that the Service Recipient did not suffer any psychological detriment as a result of the Subjects actions. (Justice Center Exhibit 35) Consequently, the Justice Center has not established that there was any actual impairment of the Service Recipient's physical, mental or emotional condition as a result of the Subject's conduct.

However, the Justice Center is not required to prove that actual impairment occurred, only that the Subject's intentional physical contact with the Service Recipient caused the likelihood of impairment. The record reflects that the Service Recipient suffered from several physical ailments

which made his bones and spine weak and susceptible to damage and breakage. (Justice Center Exhibit 34) Given the Service Recipient's physical ailments, it is determined that the Subject, who was approximately twice the weight of the Service Recipient, caused the likelihood of physical injury or serious or protracted impairment of the Service Recipient's physical, mental or emotional condition by placing half his weight on the Service Recipient and by tightly holding the Service Recipient in place to get him to fall asleep.

Consequently, the Justice Center has sufficiently established that the Subject committed physical abuse.

Allegation 1 – Abuse (deliberate inappropriate use of restraints)

The Justice Center proved by a preponderance of the evidence that the Subject committed abuse (deliberate inappropriate use of restraints) by laying in bed with the Service Recipient, holding the Service Recipient in place in his bed with his arms and legs, and placing his body weight on top of the Service Recipient.

In order to prove abuse (deliberate inappropriate use of restraints) the Justice Center must establish that the Subject used a restraint on the Service Recipient in which the technique used, the amount of force used or the situation in which the restraint was used, was deliberately inconsistent with the Service Recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies. The term "restraint" is defined by statute as any manual, pharmacological or mechanical measure or device used to immobilize or limit the ability of a service recipient to freely move his or her arms, legs or body. The statute allows, as an exception, the use of an unauthorized restraint as a reasonable emergency intervention in order to prevent imminent risk of harm to the Service Recipient or to any other person. (SSL §488(1)(d))

The record reflects that the Subject's conduct limited the Service Recipient's ability to freely move his arms, legs and body. Consequently, the Subject's conduct was a restraint as that term is defined by law. Additionally, the record reflects that the Subject's technique was not a technique that was allowed by [redacted] either as a sanctioned intervention or as an emergency intervention. Next, the Subject admitted, in the investigation and in the hearing, that his actions were deliberate. (Justice Center Exhibit 28 and Hearing testimony of the Subject) Finally, the record contains no evidence that the Subject's use of a restraint was necessary as a reasonable emergency intervention in order to prevent imminent risk of harm to the Service Recipient or to any other person.

Consequently, the Justice Center has sufficiently established that the Subject committed abuse (deliberate inappropriate use of restraints).

Allegation 2 – Neglect

The Justice Center proved by a preponderance of the evidence that the Subject committed neglect by failing to provide proper supervision of the Service Recipient which included holding the Service Recipient down in his bed, thereby restricting his ability to move.

In order to prove neglect, the Justice Center must establish that the Subject breached a custodian's duty that resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL §488(1)(h))

The record reflects that the Subject had the duty to follow the Service Recipient's treatment plans. Because none of the Service Recipient's treatments plans included the technique used by the Subject to get the Service Recipient to fall asleep, the Subject breached his duty to the Service Recipient.

Although the Justice Center did not prove that the Subject's conduct resulted in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient, the Justice Center is not required to prove that actual injury or impairment occurred, only that the Subject's conduct was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. As stated above, the record reflects that the Service Recipient suffered from several physical ailments which made his bones and spine weak and susceptible to damage and breakage, and that the Subject's conduct (placing half his weight on the Service Recipient and tightly holding the Service Recipient in place to get him to fall asleep) was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient.

Consequently, the Justice Center has sufficiently established that the Subject committed neglect.

Allegation 3 – Abuse (obstruction of reports of reportable incidents)

The Justice Center did not prove that the Subject committed abuse (obstruction of reports of reportable incidents) by failing to report and document the use of restraints on a service recipient during his bedtime. The Justice Center did not contend that the Subject failed to report the incident to the Justice Center. Instead, the Justice Center argued that the Subject failed to report and document his use of an unauthorized restraint on the Service Recipient, as he was required under [redacted] internal protocol, and that his failure to follow such protocol impeded the [redacted] investigation of the Service Recipient's bruises.

In order to prove that the Subject committed abuse (obstruction of reports of reportable incidents) by failing to report and document his use of a restraint on the Service Recipient, in accordance with [redacted] internal protocol, an action by the Subject which impeded the Justice Center

investigation, the Justice Center must establish that the Subject was a custodian and that he impeded the investigation of the Service Recipient's bruising by intentionally withholding material information during the investigation. (SSL §488(1)(f))

The record reflects that the Subject was a custodian and that he did not report or document his use of an unauthorized restraint on the Service Recipient as required by [redacted] protocol. The record also reflects that the Subject's failure to report or document the unauthorized restraint prolonged the investigation. (Hearing testimony of [redacted], [redacted] Regional Residential Director) Furthermore, the Subject testified that he knew that [redacted] protocol required him to report and document his use of an unauthorized restraint on the Service Recipient. However, the Subject explained that he failed to report and document the restraint as required because he forgot to do so due to the chaotic nature of the IRA at the time. There is no other evidence in the record concerning the Subject's intent. Consequently, the Justice Center has not established that the Subject acted intentionally when he failed to report or document his use of an unauthorized restraint on the Service Recipient and, in turn, has not proved by a preponderance of the evidence that the Subject committed abuse (obstruction of reports of reportable incidents)

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, abuse (deliberate inappropriate use of restraints) and neglect alleged. The substantiated report will not be amended or sealed as it relates to Allegation 1 and Allegation 2. The Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the abuse (obstruction of reports of reportable incidents) alleged. The substantiated report will be amended and sealed as it relates to Allegation 3.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of abuse and neglect set forth in the substantiated report. Category 2 includes conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient. (SSL § 493(4)(b)) Given the Service Recipient's diagnoses of osteoporosis of the hips, osteoporosis of the femoral necks and osteopenia of the lumbar spine, it is concluded that the Subject's use of half his body weight (approximately the full weight of the Service Recipient), together with the use of his arms and legs, seriously endangered the health, safety and welfare of the Service Recipient. Consequently, based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 2 act.

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

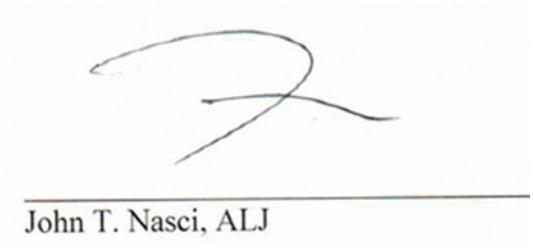
DECISION: The request of [redacted] that the substantiated report dated [redacted], be amended and sealed is denied as it relates to Allegation 1 and Allegation 2. The Subject has been shown by a preponderance of the evidence to have committed physical abuse, abuse (deliberate inappropriate use of restraints) and neglect.

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

The request of [redacted] that the substantiated report dated [redacted], be amended and sealed is granted as it relates to Allegation 3. The Subject has not been shown by a preponderance of the evidence to have committed abuse (obstruction of reports of reportable incidents).

This decision is recommended by John T. Nasci, Administrative Hearings Unit.

DATED: April 5, 2017
Schenectady, New York



John T. Nasci, ALJ