

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

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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]

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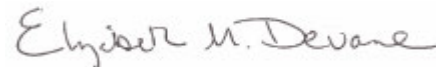
The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision is hereby adopted in its entirety.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

This decision is ordered by Elizabeth M. Devane, ALJ, of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: September 16, 2020  
Schenectady, New York



Elizabeth M. Devane, Esq.  
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register  
Kristin Kopach, Esq.  
[REDACTED], Subject, Pro se



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

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjud. Case #:**

[REDACTED]

Before:

Keely D. Parr  
Administrative Law Judge

Held at:

Video Conference Hearing  
Administrative Hearings Unit  
New York State Justice Center for the Protection  
of People with Special Needs  
9 Bond Street – 3<sup>rd</sup> Floor  
Brooklyn, New York 11201  
On: [REDACTED]

Parties:

New York State Justice Center for the Protection  
of People with Special Needs  
161 Delaware Avenue  
Delmar, New York 12054-1310  
By: Kristin Kopach, Esq.

[REDACTED]



### **JURISDICTION**

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for neglect and physical 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 neglect and physical 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 or about [REDACTED], while away from [REDACTED], located at [REDACTED], you committed Neglect against/to a Service Recipient.

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

The investigation revealed that the subject failed to use approved techniques, by grabbing and/or pushing the service recipient, or otherwise acting in an aggressive manner.

#### **Allegation 2**

It was alleged that on or about [REDACTED], while away from [REDACTED], located at [REDACTED], you committed physical abuse against/to a Service Recipient.



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

The investigation revealed that the subject grabbed and/or pushed the service recipient.

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

4. The facility, located at [REDACTED], is an individualized residential alternative (IRA) certified by the Office for People With Developmental Disabilities (OPWDD), which is a provider agency that is subject to the jurisdiction of the Justice Center. (Justice Center Exhibit 8)

5. At the time of the alleged incidents, the Subject had been employed by OPWDD for approximately 30 years and worked at the facility as the House Manager, Developmental Assistant 2 (DA2). (Hearing Testimony of Subject; Justice Center Exhibits 6 and 22)

6. At the time of the alleged incidents, the Service Recipient was a 43-year old female, operating in the moderate range of intellectual disability and diagnosed with schizoaffective disorder, bipolar type; intermittent explosive disorder and emerging obsessive-compulsive disorder (OCD). The Service Recipient had a history of verbal and physical abuse. The Service Recipient received monthly psychiatric consultations and was prescribed psychotropic medications to decrease her psychiatric symptoms and aid in the management of her behavior. One month prior to the alleged incidents, the Service Recipient's medication and dosages were changed frequently, and it was harder and harder for the staff to redirect her. On [REDACTED], the psychiatrist noted that the Subject had great tools for redirecting the Service Recipient's stuck behaviors, which he observed to be very effective. (Hearing Testimony of Subject; Justice Center Exhibits 15, 17, 19 and 21)



7. On [REDACTED], the Subject took the Service Recipient to [REDACTED] Medical Center [REDACTED] for appointments with her cardiologist and primary care doctor (doctor)<sup>1</sup>. The Subject always helped the Service Recipient onto the examination table as there was a step and it was necessary for the Subject to hold the Service Recipient as she turned around to sit down. In addition, the Subject stood right next to the Subject as she was on the examination table and kept her hands on her to steady her. (Hearing Testimony of Subject; Justice Center Exhibits 6, 17 and 28)

8. During the visit with the doctor, the Subject requested that he complete paperwork for another service recipient to enable that service recipient to participate in the Special Olympics. The doctor stated that he did not have the time. The Subject again requested that the doctor complete the paperwork, informing him that if the paperwork was not completed that the service recipient would not be able to participate in the Special Olympics. The doctor again refused. The Subject left his office with the Service Recipient and requested that his office staff facilitate completion of the paperwork, which they did. The Subject and the Service Recipient returned to the facility. (Hearing Testimony of Subject; Justice Center Exhibits 6, 17 and 28)

9. On [REDACTED], Staff #1<sup>2</sup> took the Service Recipient to the doctor. Staff #1 stated that the doctor informed her that another staff/the Subject was yelling and forcibly pushed the Service Recipient down in her chair. When Staff #1 returned to the facility, she told the Subject that she did not know what she had done to the doctor but that the doctor was mad at her. Staff #1 also informed the Subject that the doctor refused to fill out the Service Recipient's paperwork because the Subject had written in another appointment on the form. The Subject drove to [REDACTED] [REDACTED] to obtain the Service Recipient's completed paperwork from the doctor, where she waited for

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<sup>1</sup> [REDACTED]

<sup>2</sup> [REDACTED]



over an hour. (Hearing Testimony of Subject; Justice Center Exhibits 11, 16, 17 and 28)

10. The doctor stated that his staff telephoned the facility after receiving the telephone number from one of the health aides and left a message but never heard back. The treatment team leader<sup>3</sup> stated that she returned the doctor's call but never heard back. [REDACTED]

[REDACTED] (Justice Center Exhibits 6, 8 and 28)

11. On [REDACTED], a body check was conducted on the Service Recipient and no injuries were found. No injuries were documented on the Service Recipient's continuing notes, which were updated daily. (Justice Center Exhibits 6, 9 and 17)

12. The doctor described the alleged incident as follows: The Service Recipient was sitting on the examination table and he removed the chair, wanting the Service Recipient to go back on the examination table so he could examine her stomach. The Subject pushed the Service Recipient back on the examination table without saying anything to the Service Recipient such as requesting that she move back. The doctor specified, "she does not hurt the patient, but she's not nice enough". "She will be like yes, why don't you go back and like kind of push her up a little back which obviously there is no signs of bruise or trauma or any injuries there, but she will be you know, like a little rough in her hand". When questioned as to whether the Subject had her hands on the Service Recipient and was making her go back or whether it was a quick movement, the doctor replied that it "was a quick movement like a quick push". (Justice Center Exhibit 28)

13. The Service Recipient's Behavior Support Plan (BSP) indicated that physical interventions were removed from her plan, as the Service Recipient's medication changes had helped stabilize her behaviors. Physical intervention was only allowed in the event of an emergency and after an attempt to redirect the Service Recipient. (Justice Center Exhibit 19)

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<sup>3</sup> [REDACTED]



14. The doctor originally stated that the Subject was yelling at both him and his staff to complete the paperwork for another service recipient, however during his second interview stated: “she was more yelling all to my staff...”. The doctor additionally stated that he did not witness a change in the Service Recipient’s behavior when the Subject was yelling, due to the Service Recipient’s diminished intellectual capacity. (Justice Center Exhibit 28)

15. Staff #2<sup>4</sup> stated that the Subject speaks loudly, however not in an angry way and that the Subject is wonderful with the Service Recipient. Staff #2 additionally stated that the service recipients are not afraid or intimidated by the Subject when she speaks loudly. Staff #3<sup>5</sup> stated that the Subject raises her voice to the service recipients but has not noticed a change in their behaviors. (Justice Center Exhibits 6 and 28)

16. Staff #4<sup>6</sup> stated that the Subject and the Service Recipient had a great relationship and that the Subject was “outstanding” with the Service Recipient. She additionally stated that the Subject was loving and nurturing to the Service Recipient and went above and beyond for her, including buying her stuffed animals. The Service Recipient’s Person Centered Service Plan (PCSP), dated [REDACTED] stated that the Service Recipient “has a wonderful relationship with” the Subject and is happy living in the facility. (Justice Center Exhibits 6, 22 and 28)

### 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.

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- 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 physical abuse and/or neglect of a person in a facility is defined by SSL § 488(1) as:

(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. 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.

(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 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 physical abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the categories of physical abuse and neglect as set forth in the substantiated report. (Title 14 NYCRR § 700.10(d))

If the Justice Center proves the alleged physical abuse and 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 physical abuse and neglect cited in the substantiated report constitutes the categories of physical abuse and neglect as set forth in the substantiated report.

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

### **DISCUSSION**

In support of its substantiated findings, the Justice Center presented a number of documents and audio interviews obtained during the investigation. (Justice Center Exhibits 1-28) The investigation underlying the substantiated report was conducted by Justice Center Investigator [REDACTED], who was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and provided no other evidence.



### **Allegation of Neglect**

The Justice Center has not established by a preponderance of the evidence that the Subject committed an act, described as “Allegation 1” in the substantiated report. Specifically, the evidence does not establish that the Subject committed neglect.

In order to sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that her breach either 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))

On the day of the alleged neglect, the Subject was employed by the facility as a DA2 and was clearly a custodian as that term is defined in Social Services Law § 488(2). The Subject had a duty to ensure the safety and wellbeing of the Service Recipient and to follow the Service Recipient’s BSP, using only approved techniques stated therein. The Subject breached that duty by pushing the Service Recipient back onto the examination table without first requesting that she lie back and by yelling at the doctor’s staff in front of the Service Recipient. Physical intervention was only allowed in an emergency and after an attempt to redirect the Service Recipient. (Hearing Testimony of Investigator; Justice Center Exhibits 19 and 28)

Staff #1 stated that the doctor informed her that another staff/the Subject forcibly pushed the Service Recipient down in her chair. During the doctor’s interview, he stated that the Service Recipient was sitting on the examination table and that he removed the chair, wanting the Service Recipient to go back on the examination table so he could examine her stomach. The doctor stated that the Subject pushed the Service Recipient back on the examination table without saying anything to the Service Recipient such as requesting that she move back. The Subject credibly



testified that she always helped the Service Recipient onto the examination table as there was a step and it was necessary for the Subject to hold the Service Recipient as she turned around to sit down. In addition, the Subject testified that she stood right next to the Service Recipient when she was on the examination table and kept her hands on her to steady her. The Subject denied pushing the Service Recipient. (Hearing Testimony of Subject; Justice Center Exhibits 6, 8 and 28)

The Subject additionally testified that the Service Recipient was exhibiting increasing behaviors due to frequent medication changes and as a result, it was getting harder and harder to redirect her. This testimony is corroborated by both the psychiatric consultation form which documents the medication and dosage changes beginning one month prior to the alleged incidents, and the continuing notes for the Service Recipient, which state as follows: On [REDACTED], one day before the alleged incidents, Staff #5<sup>7</sup> stated that the Service Recipient was “extremely difficult to verbally redirect” and “has trouble completing normal tasks”. The afternoon of the date of the alleged incidents, Staff #4 stated that as they were about to go in the back room, the Service Recipient refused to move and “slid herself to the floor”. (Hearing Testimony of Subject; Justice Center Exhibits 6, 15, and 17)

Notwithstanding that it was difficult to redirect the Service Recipient on the date of the alleged incidents, there is no evidence in the record that the Subject even tried. The doctor stated: “She will be like go back and just push her back right there ...without telling the patient like hey can you just move back, this is what the doctor’s asking you and I’m gonna put you back.” Accordingly, the Subject breached her duty to the Service Recipient by not directing her to move back prior to pushing the Service Recipient back onto the examination table. (Hearing Testimony of Subject; Justice Center Exhibits 6, 8 and 28)

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<sup>7</sup> [REDACTED]



The Subject testified that the doctor was mad at her because she repeatedly requested that he complete forms to enable another service recipient to participate in the Special Olympics and the doctor refused, stating that he did not have the time. The Subject then left his office with the Service Recipient and requested that his office staff facilitate completion of the paperwork, which they did. The doctor originally stated that the Subject was yelling at both him and his staff to fill out the forms, in front of the Service Recipient, however during his second interview stated, “she was more yelling all to my staff”. (Hearing Testimony of Subject; Justice Center Exhibit 28)

During his interviews, the doctor recounted multiple occurrences where he found the Subject to be “rude and misbehaving” such as requesting that he fill out forms for another service recipient, writing an appointment on a form that was the doctor’s place to complete, allegedly speaking to him about the psychiatrist and the Service Recipient’s medication changes, “yelling all to my staff”, etc. The Subject argued that the doctor was not truthful and although the doctor clearly did not consider the Subject’s manner as “professional”, this does not give rise to the doctor falsifying allegations. Accordingly, the doctor’s statements are credited; the Subject pushed the Service Recipient onto the examination table without requesting that she go back and yelled at the doctor’s staff in front of the Service Recipient. (Hearing Testimony of Subject; Justice Center Exhibit 28)

The Subject’s breach did not result in nor 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))

A body check was performed on the Service Recipient on [REDACTED], which evidenced no injuries. There was no indication of any injuries in the continuing notes for the Service Recipient which were updated daily, including the date of the alleged incidents. The



Justice Center argued that the Service Recipient could have fallen off the examination table, however the doctor's statements and the Subject's testimony refute that assertion. The doctor stated that the Service Recipient was seated on the examination table with the back support inclined to the back, therefore the push resulted in the Service Recipient laying back on the examination table. In addition, the Subject credibly testified that she stood right next to the Subject when she was on the examination table and kept her hands on her to steady her. (Hearing Testimony of Investigator and Subject; Justice Center Exhibits 6, 9, 10, 17, and 28)

When describing the alleged incident and referring to the Subject, the doctor stated, "she does not hurt the patient, but she's not nice enough". "She will be like yes, why don't you go back and like kind of push her up a little back which obviously there is no signs of bruise or trauma or any injuries there, but she will be you know, like a little rough in her hand". Although Staff #1 stated that the doctor informed her that the Subject "forcibly" pushed the Service Recipient, the investigator acknowledged that there was an interpersonal conflict between Staff #1 and the Subject, and Staff #1 stated that her and the Subject did not get along. In addition, during the doctor's second interview when asked by the investigator as to whether the push was forceful, he stated that "it's a very unclear way to say" and a few moments later stated that "it did not look professional". Accordingly, as the doctor neither stated nor implied during his two interviews that there was any force behind the push, Staff #1's characterization is not credited. (Hearing Testimony of Investigator; Justice Center Exhibits 6, 8, 11 and 28)

The investigator also questioned the doctor as to whether the Subject had her hands on the Service Recipient and was making her go back or whether it was a quick movement and the doctor replied that it "was a quick movement like a quick push". Given the Service Recipient's diagnoses and behavior changes, the facts that the push was quick, not "forceful" and resulted in the Service



Recipient lying back on the examination table with the Subject standing right next to her, along with the doctor's statement that the Subject "does not hurt the patient", there was no serious or protracted impairment of the Service Recipient's physical, mental or emotional condition or likelihood thereof. (Hearing Testimony of Subject; Justice Center Exhibits 15, 17, 19, 21, and 28)

The doctor was also questioned as to whether he saw any change in the Service Recipient's behavior when the Subject was yelling and he replied no, due to her diminished intellectual capacity. The Subject testified that she was not yelling but speaks in a loud voice most of the time, without causing any harm to the Service Recipient. This testimony was corroborated by Staff #2 who stated that the Subject speaks loudly, however not in an angry way and by Staff #3 who stated that the Subject raises her voice to the service recipients but has not noticed a change in their behaviors. (Hearing Testimony of Subject; Justice Center Exhibits 6 and 28)

Staff #4 stated that the Subject and the Service Recipient have a great relationship and that the Subject is "outstanding" with the Service Recipient. The Service Recipient's Person Centered Service Plan (PCSP), dated [REDACTED] states that the Service Recipient "has a wonderful relationship with" the Subject and is happy living in the facility. Accordingly, the Subject speaking loudly/yelling does not impact the mental and emotional condition of the Service Recipient, as she appears to do this all the time, as part of her character. (Justice Center Exhibits 6 and 22)

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will be amended and sealed.

### **Allegation of Physical Abuse**

The Justice Center has not established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 2" in the substantiated report. Specifically, the



evidence does not establish that the Subject committed physical abuse.

In order to sustain an allegation of physical abuse, the Justice Center must prove by a preponderance of the evidence that the Subject was a custodian who had physical contact with the Service Recipient; that such contact was either intentional or reckless; and that such contact caused either physical injury or serious or protracted impairment of a Service Recipient's physical, mental or emotional condition; or caused the likelihood of such injury or impairment.

On the day of the alleged physical abuse, the Subject was employed by the facility as a DA2 and was clearly a custodian as that term is defined in Social Services Law § 488(2). The incident was originally reported as the Subject pushing the Service Recipient on the chair. During the doctor's interview, he clarified that the Service Recipient was sitting on the examination table and that he removed the chair, wanting the Service Recipient to go back on the examination table so he could examine her stomach. The doctor stated that the Subject pushed the Service Recipient back on the examination table without saying anything to the Service Recipient such as requesting that she move back. The Subject credibly testified that she always helped the Service Recipient onto the examination table as there was a step and it was necessary for the Subject to hold the Service Recipient as she turned around to sit down. In addition, the Subject testified that she stood right next to the Subject when she was on the examination table and kept her hands on her to steady her. Accordingly, the Subject had physical contact with the Service Recipient. (Hearing Testimony of Subject; Justice Center Exhibits 6, 8 and 28)

It must next be determined whether the Subject's physical contact was either intentional or reckless. The terms "intentionally" and "recklessly" are defined by Social Services Law as having the same meanings as provided in New York Penal Law. (SSL § 488(16)) New York Penal Law § 15.05(1) states that "A person acts intentionally with respect to a result or to conduct ... when



his conscious objective is to cause such result or to engage in such conduct.” New York Penal Law § 15.05(3) states that a person acts “recklessly with respect to a result or to a circumstance” when the person is “aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation.”

The Subject pushed the Service Recipient with the intent for her to lay back on the examination table. Accordingly, the Subject’s contact was intentional. (Justice Center Exhibit 28)

The Subject’s contact did not cause physical injury or serious or protracted impairment of the Service Recipient’s physical, mental or emotional condition; or cause the likelihood of such injury or impairment. (SSL § 488(1)(a)) The Justice Center argued that the Service Recipient could have fallen off the examination table, however the doctor’s statements and the Subject’s testimony refute that assertion. The doctor stated that the Service Recipient was seated on the examination table with the back support inclined to the back, therefore the push resulted in the Service Recipient laying back on the examination table. In addition, the Subject credibly testified that she stood right next to the Service Recipient when she was on the examination table and kept her hands on her to steady her. (Hearing Testimony of Investigator and Subject; Justice Center Exhibit 28)

Additionally, when describing the alleged incident and referring to the Subject, the doctor stated, “she does not hurt the patient, but she’s not nice enough”. “She will be like yes, why don’t you go back and like kind of push her up a little back which obviously there is no signs of bruise or trauma or any injuries there, but she will be you know, like a little rough in her hand”. Although Staff #1 stated that the doctor informed her that the Subject “forcibly” pushed the Service Recipient, the investigator acknowledged that there was an interpersonal conflict between Staff #1



and the Subject, and Staff #1 stated that her and the Subject did not get along. In addition, during the doctor's second interview when asked by the investigator as to whether the push was forceful, he stated: "It's a very unclear way to say" and a few moments later stated: "It did not look professional". Accordingly, as the doctor neither stated nor implied during his two interviews that there was any force behind the push, Staff #1's characterization is not credited. (Hearing Testimony of Investigator; Justice Center Exhibits 6, 11 and 28)

The investigator also questioned the doctor as to whether the Subject had her hands on the Service Recipient and was making her go back or whether it was a quick movement and the doctor replied that it "was a quick movement like a quick push". Given the Service Recipient's diagnoses and behavioral changes, the facts that the push was quick and not "forceful" and resulted in the Service Recipient lying back on the examination table with the Subject standing right next to her, along with the doctor's statement that the Subject "does not hurt the patient", there was no serious or protracted impairment of the Service Recipient's physical, mental or emotional condition or likelihood thereof. (Hearing Testimony of Subject; Justice Center Exhibits 15, 17, 19, 21, and 28)

The Justice Center also argued that there was a likelihood of emotional injury due to the Service Recipient's history of trauma from physical abuse and that the interaction could have triggered her. There is no evidence in the record to support this assertion. The Service Recipient's continuing notes for the days following the alleged incident only indicate ongoing OCD behavior consistent with her medication changes. On [REDACTED], the psychiatrist noted that the Subject had great tools for redirecting the Service Recipient's stuck behaviors, which he observed to be very effective. Multiple staff stated that the Subject had a great relationship with the Service Recipient, went beyond what was required of her, loved her, bought her stuffed animals, etc. The Service Recipient's PCP stated that the Service Recipient "has a wonderful relationship with" the



Subject and is happy living in the facility. Accordingly, there was no serious or protracted impairment of the Service Recipient's mental or emotional condition or the likelihood thereof. (Hearing Testimony of Investigator; Justice Center Exhibits 6, 15, 17, 22 and 28)

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that the Subject committed the physical abuse alleged. The substantiated report will be amended and sealed.

**DECISION:** The request of [REDACTED] that the substantiated report dated [REDACTED] [REDACTED] be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect and physical abuse.

This decision is recommended by Keely D. Parr, Administrative Hearings Unit.

**DATED:** September 2, 2020  
Brooklyn, New York

  
Keely D. Parr, ALJ