**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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**FINAL DETERMINATION AFTER HEARING**

**ADJUDICATION CASE**
[redacted]

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Juliane O'Brien, Esq.

[redacted]

By: Constance R. Brown, Esq.
Associate Counsel
CSEA, Inc.
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224

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

The substantiated report should be categorized as a Category 3.

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**: Schenectady, New York
February 12, 2015

David Molik
Administrative Hearings Unit

**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**

[redacted]

Before: Gerard D. Serlin
Administrative Law Judge

Held at: New York State Office Building
333 East Washington Street
Room 115
Syracuse, New York 13202
On: [redacted]
Written Closings submitted on [redacted]

Parties: Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Juliane O'Brien, Esq.

[redacted]

By: Constance R. Brown, Esq.
Associate Counsel
CSEA, Inc.
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224

## JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject), for abuse and/or 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 [redacted] [redacted] dated [redacted] of abuse by the Subject of the Service Recipient.

2. The initial report was investigated by the Justice Center for the Protection of People with Special Needs (Justice Center).

3. On or about [redacted], the Justice Center substantiated the report for abuse under the theory that the Subject engaged in the *deliberate inappropriate use of restraints*. The Justice Center concluded that:

> … [O]n [redacted], at the [redacted] … while acting as a custodian (YDA 3), you committed an act of abuse (deliberate inappropriate use of restraints) against a service recipient when you put your arm around her neck, placing her head in the crook of your arm and using your weight to drop her to the ground, lay on top of her and then bent over, while holding and pulling on her arms.
>
> This offense has been substantiated as Category 2 offense pursuant to Social Services Law § 493

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

5. At the time of the alleged abuse, the Subject was employed by the New York State Office of Children and Family Services (NYS OCFS), at the [redacted]. The Service Recipient was a young person, who was an adjudicated juvenile delinquent placed in the custody of OCFS, and was residing at the [redacted]. The Service Recipient was housed in the [redacted] Mental Health Unit. [redacted] is a limited secure residential facility, which houses female youth. The Subject worked as a Youth Division Aid 3 and was employed by *a facility or provider agency* that is subject to the jurisdiction of the Justice Center.

6. The Service Recipient had resided on the [redacted] unit for about six-to-eight months prior to this incident. The Service Recipient was five foot six inches tall and weighed about one hundred sixty pounds. The Service Recipient generally required a firm directive from staff. The Service Recipient had a history of assaultive behavior. (Hearing testimony of Subject)

7. On or about [redacted], at approximately 7:00 a.m., the Service Recipient complained to the Subject about it being too cold on the unit. This occurred on a Sunday and breakfast was not scheduled until 9 a.m. Six residents were present on the unit at that time. The Subject presented the Service Recipient with options such as dressing in warmer clothing or going into her bedroom to get warm. The air conditioning on the [redacted] unit was functioning well, perhaps too well, but the Subject had little to no control over the HVAC system at [redacted]. (Hearing testimony of Subject)

8. After the Unit returned from the cafeteria, where they ate breakfast, the Service Recipient again complained about the air conditioning. The Service Recipient told the Subject that she wanted to write a grievance. The time was approximately 9:30 a.m. (Hearing testimony of Subject)

9. The Service Recipient was discouraged from grieving by the Subject, who told her that she filed too many grievances and that she should "focus on important things." (Hearing testimony of Subject)

10. Nonetheless, the Subject provided the Service Recipient with materials for her to file a written grievance. The Service Recipient was agitated. The Subject walked away from the Service Recipient in an attempt to diffuse the situation. The Service Recipient followed the Subject and pushed her body against his body and pushed or leaned on the Subject with her left hand. (Justice Center Exhibit 22: Video Perspective 1)

11. The Service Recipient then attempted to strike the Subject with her right hand on the left side of the Subject's body, but the Subject deflected this attempt. The Subject secured his keys so that the keys could not be used as a weapon against him. While he was doing so, the Service Recipient utilized both of her hands to push the Subject very hard across his torso. After being pushed, the Subject stumbled back a bit, repositioned and then utilized his radio to call for assistance. It took the Subject about three seconds to call on his radio and to re-secure his radio into its holster. During this time the Service Recipient remained in an aggressive posture, front facing the Subject. (Justice Center Exhibit 22: Video Perspective 1)

12. The Subject then stepped towards the Service Recipient and attempted to secure her from the front. The Service Recipient resisted and stepped back. The Subject then grasped the back of the Service Recipient's head and, together, the Service Recipient and the Subject fell to the floor. The Subject then "tri-poded" his body over the torso of the Service Recipient but was careful to ensure that his body weight was not on the Service Recipient's torso, so that her breathing was not compromised. The Service Recipient was in the prone position. (Justice Center Exhibit 22: Video Perspective 1) (Hearing Testimony of the Subject)

13. For the next 11 seconds the Subject and the Service Recipient struggled. The Service Recipient aggressively struck the back, shoulders and head of the Subject with her fists, and she also attempted to "scoot" herself away and across the floor.

14. At the time that the Subject initiated the physical intervention, no other OCFS staff was immediately available to assist in the restraint. (Hearing testimony of Justice Center Investigator) YDA [redacted] called a "code yellow" which was a request for staff to respond for a restraint. But [redacted] was not available to assist with a restraint because he was conducting one-to-one supervision of a resident at the rear of the room. (Hearing testimony of Subject)

15. By slightly shifting his weight, the Subject secured the Service Recipient and at that time, assistance arrived and the Subject quickly transitioned to an OCFS prescribed restraint. (Justice Center Exhibit 22 –video perceptive 1) (Hearing testimony of OCFS CPM trainer [redacted]) The Service Recipient had no notable injuries when examined by facility medical staff. (Hearing testimony of Justice Center Investigator)

**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/or 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 evidence that the alleged act or acts of abuse and/or neglect occurred, …" (Title 14 NYCRR 700.3(f))

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: 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, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse and/or neglect; and pursuant to Social Services Law § 493(4), the Category of abuse and/or neglect that such act or acts constitute.

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488:

> 1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
>
> (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.
>
> (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct

or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.

(c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(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.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(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.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

(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.

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).

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

    (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

        (i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;

        (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

        (iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

        (iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

(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.

(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.

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

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 evidence, the substantiated report must be amended and sealed.

## DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed a prohibited act, as alleged in the substantiated report. The act committed by the Subject constitutes *deliberate inappropriate use of restraints*. The category of the affirmed substantiated neglect that such act constitutes is Category 3.

In support of the substantiated findings, the Justice Center presented Justice Center Exhibits 1-27. The Justice Center called two witnesses to testify in support of its case. The Subject testified and presented twelve Exhibits on his own behalf. The Subject also called one other witness on his behalf.

[redacted] hearing testimony

[redacted] (CPM), [redacted] testified at the hearing on behalf of the Justice Center. [redacted] testified that he provides instruction in the mechanics of restraints and other relevant matter pertaining to managing behavioral issues in the facilities.

In [redacted] opinion, under the relevant OCFS PPM 3247.12, the physical intervention of the Service Recipient was warranted once the Service Recipient pushed the Subject with her two hands.[1] Indeed from a plain reading of NY OCFS Crisis Prevention and Management (PPM 3247.12): Effective date: February 06, 2012,[2] it is clear that the NY OCFS Commissioner has authorized a restraint where there is a showing that the restraint is "necessary to protect the safety of any person."

The major issue expressed by [redacted] centered on the mechanics of the restraint. [redacted] testified that when the Service Recipient forcefully shoved the Subject with both hands, the Subject should have treated that attack like a "straight-punch" and transitioned to a prescribed maneuver, consistent with a "standing–arm hook," and then ultimately followed to a seated one-

[1] [redacted] briefly took the position that while the restraint was warranted immediately after the Service Recipient pushed the Subject with two hands, that the Subject did not react quickly enough to execute a physical intervention and that essentially, too much time elapsed and, that by the time the Subject acted, there was no danger. Therefore, the restraint was not warranted under the relevant OCFS polices. [redacted] "waffled" a bit under cross-examination in defending this point. In any event, as the facts adopted herein illustrate [redacted] opinion on that issue is not supported by the record.

[2] Justice Center Exhibit 7

person restraint. [redacted] testified that a prone hold always requires that three staff members be involved.

[redacted] also testified that although the team approach to restraints is preferred, single person restraints are taught to employees of OCFS and, to the Subject's "credit, he wound up in the acceptable seated restraint position at the end." OCFS staff is trained with the "understanding that things don't always go the way we expect them to, and if you find yourself in a different position, get yourself where you need to be as quickly as possible."

[redacted] Testimony

[redacted] testified on behalf of the Subject. [redacted] is a certified OCFS facility CMP trainer and had been so since October of 2013. [redacted] was assigned to the [redacted] facility. [redacted] also testified that if a restraint does "not go as planned" staff are expected to "continue to try and engage them" (the Service Recipient), into "a proper technique."

Although they had differing opinions about whether some of the actions that are captured in the video were in conformity with OCFS PPM 3247.12, [redacted] and [redacted] did not differ significantly in their testimony.

Testimony of Subject [redacted]

The Subject's hearing testimony was lengthy. [redacted] relevant testimony was as follows: Fellow staff member [redacted] was in the bathroom when the incident arose. Fellow staff member [redacted] was at rear of the unit, conducting one-to-one supervision of another Service Recipient.

All OCFS CMP prescribed single person restraints require that the staff member attempting the restraint, "spin" the Service Recipient in order to get behind the Service Recipient and ultimately end up with "hooks-in" and be seated on the floor.

When asked about standing face-to-face with a Service Recipient and the prescribed mechanics of "spinning" that Service Recipient in order to get behind them, the Subject testified that there is no prescribed technique for "spinning" a Service Recipient when starting in the face-to-face position. However, the Subject also acknowledged that he is taught in training that he can use a "one-arm hook, followed by a "spin," to rotate a Service Recipient in order to ultimately obtain the proper position. This technique can be used in a number of starting positions. The Subject testified that this technique is not effective because the Service Recipient can easily resist an attempt to "hook and spin."

The Subject testified that he never attempted a "hook and spin;" the Subject acknowledged that instead he performed what is often characterized in the record, as a headlock, by grabbing the Service Recipient shoulder and spinning the Service Recipient. The Subject testified, and attempted to demonstrate in the hearing room through re-enactment, that he was not close enough to the Service Recipient to "step-in, hook the Service Recipient's arm and spin," as he was taught.

The Subject admitted that he grabbed the Service Recipient in the shoulder area and the back of the head, that he attempted unsuccessfully to spin her and that, finally, both he and the Service Recipient fell to the ground. The Subject also argued that he was protecting himself when he attempted this non-prescribed spin.

After considering all of the evidence, while a restraint was warranted under the relevant OCFS policy, at the moment when the Subject attempted the non-prescribed portion of the restraint, by wrapping his hand around the back of the Service Recipient's head and going to the ground, the non-prescribed restraint was not a ***reasonable*** emergency intervention necessary to prevent imminent risk to the Subject. The Subject could have attempted to "step-in" to the

resident and then “hook one-arm and spin” the resident. If the Service Recipient had defeated this attempt, or resisted same, then the outcome of this analysis may have been different.

With regard to the final portion of the restraint, the Subject took the steps to ensure that his weight was not on the prone Service Recipient. While a one person prone restraint is not prescribed, the video evidence clearly illustrates that the Service Recipient was violently hitting the Subject on the back of the body and the head with her fists. Therefore, the non-prescribed single person prone restraint was a reasonable emergency intervention necessary to prevent imminent risk of harm to the Subject.

The manner in which the Subject took the Service Recipient to the floor was not a prescribed OCFS CMP restraint technique. The Subject acknowledged same in his hearing testimony. Accordingly, it is determined that this portion of the restraint constitutes a: “[d]eliberate inappropriate use of [a]restraint," as that term is so utilized in SSL § 488 (1) (d). Further, this non-prescribed technique constitutes an act of neglect.

Under 14 NYCRR § 700.6 (a), the ALJ has discretion to amend the findings of the substantiated report since it is the subject matter of the hearing, namely, “whether the findings of the report should be amended.” Section 700.6(b) specifically sets forth the Category of abuse or neglect as one of the three issues to be determined at the hearing. After considering all of the evidence and the implication of damages, it is concluded that the Subject’s non-prescribed restraint technique did not seriously endanger the health, safety or welfare of the Service Recipient. The original Offense cited in this proceeding did not take into account the Subject’s conscious effort to not harm the Service Recipient. Accordingly, the Category of Deliberate Inappropriate Restraint is hereby amended to be a Category 3 offense.

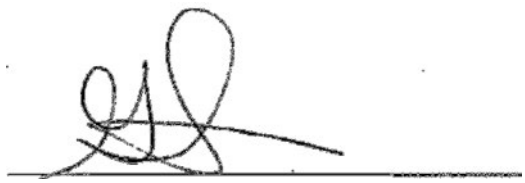
A substantiated Category 3 finding of abuse or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report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

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

The substantiated report should be categorized as a Category 3.

This decision is recommended by Gerard D. Serlin, Administrative Hearings Bureau.

**DATED**: January 23, 2015
Schenectady, New York



Gerard D. Serlin, ALJ