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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

FINAL DETERMINATION AND ORDER AFTER HEARING

Adjud. Case #: [redacted]

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

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

[redacted]
By: Laura A. Zaccone, Esq.
275 Madison Avenue, 6th Floor
New York, New York 10016

Michael Bruk, Esq.
138 W. 25th Street
10th Floor, Suite C1001
New York, New York 10001

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

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

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

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: November 22, 2016
Schenectady, New York

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjudication Case #: [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

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

Parties: Vulnerable Persons' Central Register
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
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New York, New York 10001

[redacted]

JURISDICTION

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

FINDINGS OF FACT

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

1. The VPCR contains a report of substantiated finding dated [redacted] of abuse (deliberate inappropriate use of restraints) and neglect by the Subject of a Service Recipient.

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

Allegation 1

> It was alleged that on [redacted], at the [redacted], located at [redacted] while acting as a custodian, you committed abuse (deliberate inappropriate use of restraints) and neglect when you unjustifiably ordered a service recipient to be medicated, over objection, and when you caused medication to be administered to the service recipient in a manner inconsistent with generally accepted treatment practices, regulation and/or policies.
>
> These allegations have been SUBSTANTIATED as Category 3 abuse (deliberate inappropriate use of restraints) and as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

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

4. The facility, located at [redacted], is a secure mental health residential treatment facility for adults that is operated by the New York State Office

[redacted]

of Mental Health (OMH), which is an agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse and neglect, the Service Recipient had been admitted to the facility on [redacted] and was residing in a ward for recent admissions. The Service Recipient had a history of extreme violence, schizophrenia and drug addiction, and he had been previously admitted to the facility and to at least one other facility. (Hearing testimony of the Subject)

6. At the time of the alleged abuse and neglect, the Subject had been employed as a facility psychiatrist overseeing the treatment of service recipients since [redacted] 2010. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

7. At the time of the alleged abuse and neglect, there were three ways in which facility service recipients received medication. Medication could be taken voluntarily by service recipients, could be administered pursuant to a court order providing for medication over objection, or could be administered pursuant to an emergency "stat" order made by a licensed physician or other authorized health care provider. (Hearing testimony of the Subject)

8. From his date of admission, the Service Recipient had refused all medication. As a result, an application for medication over objection had been submitted to the court; however, on [redacted], the order had not yet been issued. (Hearing testimony of the Subject)

9. At the time of the alleged abuse and neglect, there was a facility policy Restraint and Seclusion, issued on [redacted] stated that, "For behavioral management purposes, seclusion and restraint are interventions to be used only as a measure of last resort to avoid imminent injury to the patient or others." (Justice Center Exhibit 25, Part I, page 1) The policy further stated that "The use of medication to immobilize an individual is considered an inappropriate medical practice, and thus is not an acceptable method of drug used as a restraint,

[redacted]

and is prohibited." (Justice Center Exhibit 25, Part III, page 2)

10. At the time of the alleged abuse and neglect, there was another facility policy, Prescribing, Dispensing and Administration of Medications, issued on [redacted], which prohibited the prescription of controlled substances unless the prescribing doctor had personally examined and/or interviewed the service recipient, except in the case of an extreme emergency. (Justice Center Exhibit 23)

11. At the time of the alleged abuse and neglect, the Subject's immediate supervisor was Associate Clinical Director [redacted] and his supervisor was Director of Psychiatry [redacted] (Hearing testimony of the Subject)

12. On [redacted], the day before the date of the alleged abuse and neglect, the Service Recipient assaulted and injured another facility psychiatrist. As a result of that incident, the Service Recipient was administered medication by way of intramuscular injection on a "stat" basis. The administering of the medication resulted in injury to several of the facility staff. As well, the Service Recipient was assigned to have 2:1 supervision, which was an unusually high level of supervision. On that date, the Subject was not present at the facility. (Hearing testimony of the Subject)

13. On [redacted] the Subject arrived at the facility at approximately 8:20 a.m. to work her regular day shift. While the Subject was performing her routine morning rounds, she was advised of the [redacted] incident. Subsequent to the Subject's morning rounds, [redacted] and [redacted] met with the Subject and Treatment Team Leader [redacted] (TTL [redacted]), to discuss addressing the Service Recipient's unpredictable and violent conduct. [redacted] advised the Subject to have a "low threshold" for medicating the Service Recipient, meaning that she should not wait for symptoms of aggression to escalate before administering medication. (Hearing testimony of the Subject and Justice Center Exhibit 22)

[redacted]

14. At some point earlier that morning, the Service Recipient had been placed in a Treatment Mall dayroom to accommodate some construction work occurring in his assigned ward. After the meeting, the Subject and TTL [redacted] proceeded to the nearby Treatment Mall medication room. Without first entering the dayroom or speaking to the Service Recipient, the Subject wrote an order prescribing him the medications Haldol, Ativan and Benadryl by injection on a "stat' basis. TTL [redacted] informed the nurses of the plan to medicate and also summoned other staff and Safety Officers (SOs) to the Treatment Mall to assist. (Justice Center Exhibits 8 and 17)

15. Meanwhile, the Service Recipient had been sleeping for some time, while sitting in a chair with his head resting on a table and his sweatshirt pulled up over it, and he was being supervised by Mental Health Treatment Assistant (MHTA) [redacted] and MHTA [redacted] (Justice Center Exhibits 16, 18, 19, and 20)

16. When the SOs and other staff responded to requests for assistance and arrived at the Treatment Mall, they were confused because they had been called urgently but there was no commotion or other apparent reason for their presence. Ultimately, even though the Treatment Mall area was quiet, approximately thirty staff responded to the calls for assistance. (Justice Center Exhibits 16, 18, 19, and 20)

17. When asked why they were called, the Subject told the staff that they were going to medicate the Service Recipient and she instructed the staff that there should be "...no talking, just medicate." (Justice Center Exhibits 16, and 18)

18. SO [redacted] requested of the Subject that he be permitted to speak to the Service Recipient, because he had successfully persuaded the Service Recipient to allow himself to be medicated in the past. However, the Subject refused and reiterated that the Service Recipient should be medicated without discussion. (Justice Center Exhibits 15, 16, and 18)

[redacted]

19. After a delay of approximately thirty minutes, with the large crowd of staff waiting for the medication order to be filled, the Subject entered the dayroom and instructed the staff to clear the area. At that point, a group of several MHTAs and SOs also entered the dayroom. The Service Recipient was still asleep on the chair. SO [redacted] awakened the Service Recipient and spoke with him regarding the plan to medicate him, while other staff began moving furniture away from the Service Recipient in anticipation of the expected struggle that would ensue during the administering of the medication. (Justice Center Exhibits 15, 16, 17, and 18)

20. The Service Recipient questioned why he was being medicated when he had only been sleeping. SO [redacted] and other staff approached the Subject and requested that she explain her order to medicate the Service Recipient to him, to which she responded that the Service Recipient knew why, that she did not have to explain anything and that he knew what he had done the day before. The staff continued to press the Subject to speak to the Service Recipient and, ultimately, the Subject approached the Service Recipient and told him that he was being medicated because of his assault resulting in injury to the doctor the day before. Without further discussion, the Subject immediately walked away from the Service Recipient. The Service Recipient told the staff that he just woke up and that he did not understand what he had done that day to deserve medication, while acknowledging his conduct the previous day. (Justice Center Exhibits 15, 16, 17, and 18)

21. By this time, there were approximately twenty-five staff in the dayroom. While some staff continued to speak to the Service Recipient, in an attempt to avoid a violent encounter, the Subject yelled from the back of the crowd that had gathered that staff should not talk and that they should just take him down. The Service Recipient became increasingly upset and verbally threatened to kill the Subject. (Justice Center Exhibits 15, 16, 17, and 18)

22. [redacted], who had been monitoring the situation, entered the dayroom and briefly

spoke to the Service Recipient, after which the Service Recipient requested that he be permitted to take the medication orally, instead of by injection, which the Subject refused to allow. (Justice Center Exhibits 16, and 18)

23. As time progressed and the Service Recipient became increasingly agitated, staff followed the Subject's directions and physically restrained and medicated the Service Recipient. (Justice Center Exhibits 15, 16, 17, and 18)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the 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 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)(d) and (h) to include the following:

> (d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention

[redacted]

> 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.
>
> (h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient.

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

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

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

If the Justice Center proves the alleged abuse and/or neglect in a report, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the acts of abuse and/or neglect cited in the substantiated report constitute the category of abuse and/or neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed the acts described as Allegation 1 in the substantiated report.

In support of its substantiated findings, the Justice Center presented evidence obtained

during the investigation. (Justice Center Exhibits 1-27) The investigation underlying the substantiated report was conducted by then facility Risk Manager who testified on behalf of the Justice Center.

The Subject testified at the hearing on her own behalf.

The Subject's response to the allegation was twofold. Firstly, the Subject's counsel submitted that the Subject complied with facility policies and the directions of her supervisor, , when she formed the clinical opinion that it was necessary and appropriate to medicate the Service Recipient on a "stat" basis and when she wrote the order and instructed staff to administer the medication. Secondly, the Subject's counsel submitted that facility Risk Manager Investigative Report (Justice Center Exhibit 6) should not be credited as reliable evidence because facility Risk Manager did not interview did not obtain a more comprehensive statement from and inaccurately paraphrased at least one witness statement.

Although the Investigative Report may contain flaws, they are not fatal and they do not impinge on the trustworthiness of the balance of the evidence obtained during facility Risk Manager investigation. The abundance of credible evidence in the record, namely the witnesses' signed statements, provides more than enough detail as to what transpired to inform the determinations herein.

Furthermore, although facility Risk Manager did not interview during the investigation and the statement from may be brief, facility Risk Manager testimony regarding his investigative methodology was credible and satisfactory. The Subject, who was represented by counsel, had a full and fair opportunity to produce evidence supporting her position at the hearing, but she did not do so.

With respect to the Subject's version of events, she testified that since the Service

[redacted]

Recipient's arrival at the facility eight days earlier, he had refused all medication and because his behavior had been violent, aggressive and threatening, an application to medicate him over objection had been submitted to the court prior to the date of the incident, but the order had not yet been issued by the court.

The Subject testified that when she first arrived at the facility on [redacted] at approximately 8:20 a.m., prior to her morning rounds, she observed the Service Recipient displaying aggressive and threatening behavior by lying in front of the medication window and threatening passersby.

The Subject testified that thereafter, during morning rounds, she was advised that the Service Recipient had assaulted and injured another facility doctor the preceding day and that, as a result, the Service Recipient was subject to the unusual measure of 2:1 supervision, and she later learned that one of the two assigned MHTAs had expressed fear of the assignment.

The Subject testified that immediately after morning rounds [redacted] requested that she and TTL [redacted] meet with him and [redacted] to strategize regarding the Service Recipient's assaultive and unpredictable behavior. The Subject testified that during that meeting, [redacted] instructed her that even at the tiniest sign of aggression, including threats, she should be proactive, not reactive, in medicating the Service Recipient to prevent a recurrence of the violence that he had perpetrated the preceding day, and that she had simply followed her supervisor's instructions at the time that she wrote the medication order.

The Subject testified that prior to making the medication order she assessed the Service Recipient. The Subject testified that when she entered the Treatment Mall dayroom, she observed the Service Recipient sitting alone with his head down and his back to the door, with MHTA [redacted] present, supervising him from a chair in the room's far corner. The Subject testified that when she walked into the room, she saw the Service Recipient look up and turn his head to her so that she

[redacted]

could observe his face. The Subject testified that when she approached the Service Recipient and told him that she was there to evaluate him, the Service Recipient responded with, "If you touch me, you will see what happens" and that when she reiterated her reason for being there, the Service Recipient just gave her a hostile look and repeated himself. The Subject testified that she saw rage in the Service Recipient's eyes and felt that, even though he remained seated, he was about to pounce on her. The Subject testified that the encounter allowed her to assess the Service Recipient's condition and she formed the clinical opinion that it was necessary to medicate him on a "stat" basis.

The Subject testified that she later heard the nursing staff argue about who would have to administer the injection because they were afraid of the Service Recipient and that it took a large number of people to be present when the injection was administered because the Service Recipient was so aggressive, unpredictable and threatening.

The Subject's interrogation by facility Risk Manager [redacted] on [redacted] was recorded and transcribed. (Justice Center Exhibits 26 and 27) A comparison between the Subject's interrogation answers and her testimony reveal some discrepancies. In her interrogation, the Subject stated that TTL [redacted] entered the dayroom with her initially and that she was only able to say the Service Recipient's name once before he cut her off threateningly, which contradicted her testimony. Furthermore, in her testimony, the Subject repeatedly mentioned that prior to her morning rounds she had already observed the Service Recipient lying on the floor near the medication window and threatening people, a detail that was not included in her interrogation answers. Although there were other similar inconsistencies in her answers, further analyzing the two different records of the Subject's version of events is unnecessary. The record includes seven witness statements (Justice Center Exhibits 15- 22), as well as the Incident Report (Justice Center Exhibit 7), which all credibly contradict the Subject's testimony and interrogation answers

regarding whether the Subject interviewed, observed or assessed the Service Recipient prior to ordering that he be medicated and whether the medication was necessary at the time that it was ordered. Despite this finding, however, the onus remains on the Justice Center to prove by a preponderance of the evidence that the Subject committed the acts as alleged.

Abuse (Deliberate Inappropriate Use of Restraints)

Because there is no allegation that excessive force or improper technique was used, the issue that arises in this case is whether the Subject used a pharmacological restraint against the Service Recipient that was deliberately inconsistent with generally accepted treatment practices and/or facility policy and, if so, whether it was a reasonable emergency intervention to prevent imminent risk of harm to either the Service Recipient or to someone else.

The first question is whether the Subject's "stat" order that the Service Recipient receive the drugs Haldol, Ativan and Benadryl by way of intramuscular injection constituted a restraint. Under SSL § 488(1)(d) the definition of "restraint" includes the use of any pharmacological measure to immobilize or limit the ability of the Service Recipient to freely move his arms, legs or body. The Subject testified that, although this combination of medications was an appropriate treatment regimen for psychosis, she ordered that the Service Recipient receive the injection on a "stat" basis because she was seeking to curtail the Service Recipient's aggression and unpredictability. In short, the purpose of the medication order was to chemically subdue the Service Recipient to immobilize or limit his ability to freely move his arms, legs or body.

The second question is whether the restraint was inconsistent with generally accepted treatment practices and/or facility policy. Under the facility Restraint and Seclusion policy (Justice Center Exhibit 25), the only exception to the prohibition against the use of a pharmacological restraint on a service recipient is as a last resort to avoid imminent injury to the service recipient or to others. The Subject testified that when she wrote the order for the Service Recipient's

[redacted]

medication, it was her clinical opinion that it was necessary to immediately medicate the Service Recipient because he had threatened her and seemed filled with rage.

The Subject's testimony that the Service Recipient was threatening and aggressive that morning was contradicted by all of the other evidence in the record. Seven other witnesses were interviewed by facility Risk Manager [redacted] and provided signed statements that unanimously indicate that, at no time prior to preparing to administer the medication to the Service Recipient, was his conduct threatening or aggressive. In fact, all of the witnesses who were present in the dayroom that morning reported that the Service Recipient was sleeping when they arrived, that he was awakened only by SO [redacted] and by other staff moving furniture, and that the Service Recipient's demeanor turned angry and aggressive only after the Subject spoke to him.

Even the Subject reluctantly admitted during her testimony that when she did observe the Service Recipient he was sitting. Given this admission and, more significantly, the statements of the seven other staff, it is clear that the Service Recipient presented no threat of imminent injury and that his conduct did not justify the use of the pharmacological restraint pursuant to facility policy. Furthermore, the Subject's statement that she was only following the orders of [redacted] did not exempt her from the clearly articulated facility policy that the use of medication to immobilize service recipients was prohibited unless it was necessary to avoid imminent risk of harm.

The other relevant facility policy with which the Subject was required to comply, Prescribing, Dispensing and Administration of Medications (Justice Center Exhibit 23), prohibits the prescription of controlled substances unless the prescribing doctor personally examined and/or interviewed the service recipient, except in the case of an extreme emergency.

The Subject testified that prior to ordering the "stat" medication, which is a controlled substance, she had complied with this requirement by interviewing or assessing the Service

[redacted]

Recipient. None of the seven signed witnesses' statements corroborates the Subject's assertion that she entered the Treatment Mall dayroom and spoke to the Service Recipient prior to ordering that he be medicated, and they all provide clear narratives that specifically establish that the Subject wrote the medication order before she interacted with the Service Recipient.

The signed statements of Senior Recreational Therapist Howze (Justice Center Exhibit 20), MHTA [redacted] (Justice Center Exhibit 19), MHTA [redacted] (Justice Center Exhibit 18), MHTA [redacted] (Justice Center Exhibit 15), and SO [redacted] (Justice Center Exhibit 16) all provide the firsthand account of witnesses who were present and involved in the incident. Each of the statements indicate that, at the time that the Service Recipient was awakened by SO [redacted] and the commotion of the furniture being cleared away, the Subject had already written the medication order. Similarly, the statement of the Service Recipient (Justice Center Exhibit 14) and the narrative in an unsigned Incident Report (Justice Center Exhibit 7) both indicate that the Service Recipient had been asleep at the relevant time and that the Subject did not speak to him prior ordering that he be medicated.

The statement of TTL [redacted] (Justice Center Exhibit 17) is particularly compelling because it is clear that she was attempting to be supportive of the Subject in her narrative of events. Her statement indicates that she was with the Subject during morning rounds, during the meeting with [redacted] and during the time that the Subject was in the Treatment Mall prior to the time that the Service Recipient received the medication. TTL [redacted] statement indicates that the Subject wrote the medication order immediately after the meeting with [redacted] TTL [redacted]' statement indicates that when she and the Subject went to the Treatment Mall, the Service Recipient was asleep and that it was SO [redacted] who had awakened him after the Subject announced that she had ordered that he be medicated.

The statement of MHTA [redacted] (Justice Center Exhibit 21) is also significant because she

[redacted]

was in the dayroom as one of the Service Recipient's 2:1 supervisors throughout the incident. MHTA [redacted] statement indicates that she was with the Service Recipient in the Treatment Mall dayroom that morning and that he had been sleeping with his head down and his sweatshirt pulled over his head when the Subject entered and instructed her to clear the area because the Service Recipient was going to be medicated. MHTA [redacted] statement indicates that instead of explaining to the Service Recipient why he was being medicated, the Subject "stormed" into the dayroom, said something to the Service Recipient and walked out, and that she seemed to be upset. MHTA [redacted] statement indicates that the Service Recipient was not agitated before staff entered the dayroom and told him that he was going to be medicated.

Accordingly, the evidence in the record shows that the Subject did not comply with the facility policy requirement that she examine and/or interview the Service Recipient prior to ordering that he be medicated, despite her claims that she had done so.

Although it was not explicitly argued, the Subject also seemed to rely on the assertion that she had only been following the directive of her supervisor, [redacted], and that in doing so, she had complied with generally accepted treatment practices. However, [redacted] credibly asserted in his statement that he did not advise the Subject to medicate the Service Recipient without assessing him first when he told her to have a low threshold for medicating the Service Recipient. (Justice Center Exhibits 6 and 22)

Accordingly, under the circumstances, the Subject's decision to order that the Service Recipient be medicated on a "stat" basis was inconsistent with both facility policy and generally accepted treatment practices.

The last question is whether the deliberate improper use of a restraint was a reasonable emergency intervention to prevent imminent risk of harm to the Service Recipient or to someone else. As discussed above, the facts and the evidence in the record illustrate that this was not an

[redacted]

emergency intervention to prevent imminent risk of harm to anyone. After considering all of the evidence, the Justice Center has established by a preponderance of the evidence that the Subject's conduct constituted abuse (deliberate inappropriate use of restraints) as defined by SSL § 488(1)(d).

Neglect

Regarding the allegation of neglect under SSL § 488(1)(h), a finding requires firstly that the Subject engaged in conduct that breached her duty to the Service Recipient. In this case, the Subject's duty to the Service Recipient included adhering to facility policy in her medical treatment of the Service Recipient. The above analysis of SSL § 488(1)(d) establishes that the Subject ordered that the Service Recipient be medicated, not only without interviewing and/or examining him first, but also when there was no imminent risk of harm to the Service Recipient or to anyone else that may have justified an emergency intervention. All of the evidence in the record indicates that the Subject's conduct was not authorized by facility policy and her departure from facility policy was a breach of her duty to the Service Recipient.

A finding of neglect also requires that the Subject's breach of duty 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. It was acknowledged by the Subject that the Service Recipient was known to become violent and it was foreseeable that administering medication to him without his consent would provoke him. The Subject was so aware of this fact that she summoned a large number of staff to be present and to assist with physically controlling the Service Recipient while the medication was being administered. Accordingly, and considering the inherent risks of a physical and pharmacological restraint to the Service Recipient, it is concluded that the Subject's breach of duty was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. Accordingly, the Subject's

[redacted]

conduct constituted neglect as defined by SSL § 488(1)(h).

Conclusion

Based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the act as specified in Allegation 1 of the substantiated report. The report will remain substantiated.

The next issue to be determined is whether the substantiated report constitutes the category of abuse (deliberate inappropriate use of restraints) and neglect set forth in the substantiated report**.** Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act. Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496(2). The report will be sealed after five years.

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

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

[redacted]

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

DATED: November 3, 2016
Plainview, New York