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]

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: January 7, 2019
Schenectady, New York

Elizabeth M. Devane

Elizabeth M. Devane, Esq.
Administrative Hearings Unit

cc. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Emily Hannigan, Esq.

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

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: John T. Nasci
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
401 State Street
Schenectady, New York 12305
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: Todd Sardella, Esq.

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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating Subject [redacted] for neglect and Subject [redacted] for neglect and abuse (obstruction of reports of reportable incidents). The Subjects requested that the VPCR amend the report to reflect that the Subjects are not subjects 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 by Subject [redacted] and, neglect and abuse (obstruction of reports or reportable incidents) by Subject [redacted] of a Service Recipient.

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

Allegation 1

It was alleged that on the overnight shift between [redacted] and [redacted][1], at the [redacted], located at [redacted], while a custodian, you committed neglect when you fell asleep or were less than alert while on duty, and/or otherwise failed to provide a service recipient with proper supervision.

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

3. The Justice Center substantiated the report against the Subject [redacted]. The

[1] At the hearing, the parties stipulated that the dates stated in the Allegation were incorrect and that the actual overnight shift in question was from [redacted] to [redacted]. (Hearing record)

Justice Center concluded that:

Allegation 1

It was alleged that on the overnight shift between [redacted] and [redacted][2], at the [redacted], located at [redacted], while a custodian, you committed neglect when you fell asleep or were less than alert while on duty, and/or otherwise failed to provide a service recipient with proper supervision.

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

Allegation 2

It was alleged that on the overnight shift between [redacted] and [redacted][3], at the [redacted], located at [redacted], while a custodian, you committed abuse (obstruction of reports of reportable incidents) when you falsified records related to a service recipient's safety and supervision.

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

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

5. The facility, the [redacted], located at [redacted], is a facility for the inpatient treatment of people with mental illnesses, and is operated by the New York State Office of Mental Health (OMH), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted], Justice Center Investigator (Investigator))

6. At the time of the alleged neglect and abuse, Subject [redacted] had been employed by the OMH as a Secure Hospital Treatment Aide (SHTA) for approximately sixteen years. (Justice Center Exhibit 27: audio recording of Justice Center interrogation of Subject

[2] See footnote 1.
[3] See footnote 1.

[redacted] and Hearing testimony of Subject [redacted]) At the time of the alleged neglect, Subject [redacted] had been employed by the OMH as a Secure Hospital Treatment Aide (SHTA) for approximately three years. (Justice Center Exhibit 27: audio recording of Justice Center interrogation of Subject [redacted]; and Hearing testimony of Subject [redacted]) The Subjects were both custodians as that term is defined in Social Services Law § 488(2).

7. At the time of the alleged neglect and abuse, the female Service Recipient was fifty-seven years old, had been a resident of the facility since 1997 and was a resident of the facility's Ward [redacted]. (Justice Center Exhibit 20) The Service Recipient had a history of assaultive and self-abusive behaviors. (Hearing testimony of the Investigator)

8. On [redacted], the Service Recipient purposefully cut her left forearm and was treated with sutures and bandaged. As a result of the Service Recipient's self-abusive behavior, she was placed on one-to-one (1:1) supervision and remained on 1:1 supervision through [redacted]. (Justice Center Exhibit 26 and Hearing testimony of the Investigator)

9. Facility policy regarding 1:1 supervision, in pertinent part, required SHTA staff to "ensure there are no physical barriers between them and the patient … that would prevent immediate intervention," "maintain a distance of arm's length plus 12 inches from the patient," and "maintain continuous visual contact at all times." Additionally, for service recipients on 1:1 supervision, SHTA staff were required to document the service recipients' mental, physical and behavioral status every fifteen minutes, and the service recipients' specific behaviors and staff interventions as they may occur. (Justice Center Exhibit 24) Specific additional supervision/observation requirements for the Service Recipient at the time of the alleged neglect included having the bedroom light on for the entire night and having the Service Recipient's hands visible at all times. (Justice Center Exhibit 22)

10. On the overnight shift from [redacted], at 11:00 p.m. to [redacted], at 7:00 a.m., the Subjects' co-worker [redacted] (SHTA1) and the Subjects were assigned to SHTA duties on Ward [redacted]. During the overnight shift, all three SHTAs were assigned to 1:1 supervision of the Service Recipient in the following shifts: SHTA1 between 11:00 p.m. and 1:00 a.m.; Subject [redacted] between 1:00 a.m. and 3:00 a.m.; Subject [redacted] between 3:00 a.m. and 5:00 a.m.; and SHTA1 between 5:00 a.m. and 7:00 a.m. (Justice Center Exhibit 18) The facility SHTAs, including the Subjects, performed 1:1 supervision duties by sitting in a chair, in the doorframe of the Service Recipient's room, positioned perpendicular to the room, and facing the Service Recipient, who was lying in her bed with her head near the door frame of the room. This position placed the SHTAs within arm's length plus twelve inches and provided them with an unobstructed view of the Service Recipient. (Justice Center Exhibit 27: facility surveillance video recording of the shift and Hearing testimonies of the Subjects and SHTA1)

11. SHTA1 first performed 1:1 supervision duties from 11:00 p.m. [redacted], until 1:00 a.m. [redacted]. During that timeframe, SHTA1 documented the Service Recipient's status at 11:15 p.m., 11:30 p.m., 11:45 p.m., 12:00 midnight, 12:15 a.m., and 12:30 a.m. During the remainder of SHTA1's first 1:1 supervision shift, Subject [redacted] documented the Service Recipient's status at 12:45 a.m. (Justice Center Exhibits 22 and 27: audio recording of Justice Center interrogation of SHTA1; and Hearing testimony of SHTA1)

12. During the beginning of SHTA1's first 1:1 supervision shift, SHTA1 performed a routine search of the Service Recipient and found a bite mark on her right wrist. The Service Recipient told her that she had bitten her right arm during the previous shift. In response, SHTA1 summoned the senior SHTA [redacted] (senior SHTA) and a facility nurse who both

examined her and found no need for further action. (Justice Center Exhibits 16, 17 and 27: audio recording of Justice Center interview of Senior SHTA and interrogation of SHTA1; and Hearing testimony of SHTA1) The senior SHTA documented the incident. (Justice Center Exhibit 22)

13. From 1:00 a.m. until 1:30 a.m., it is unclear from the evidence in the record which SHTA actually performed 1:1 supervision duties for the Service Recipient. However, during that timeframe, Subject [redacted] documented the Service Recipient's status at 1:00 a.m., 1:15 a.m. and 1:30 a.m. Subject [redacted] also documented the Service Recipient's status at 1:45 a.m., 2:00 a.m., 2:15 a.m., 2:30 a.m., 2:45 a.m., and 3:00 a.m. (Justice Center Exhibit 22)

14. Although Subject [redacted] was assigned to perform 1:1 supervision duties from 1:00 a.m. to 3:00 a.m., from at least 1:30 a.m. until approximately 4:57 p.m., Subject [redacted] undertook to perform such duties. At approximately 1:42 a.m., Subject [redacted] sat down in a chair in the hallway across from the Service Recipient's doorway, approximately five feet from the doorway. At the same time, Subject [redacted], who was wearing sunglasses and a hooded sweatshirt with the hood over her head, turned to look at Subject [redacted], then turned her head down and away from the room. Subject [redacted] remained in this position, motionless, from approximately 1:42 a.m. until approximately 2:08 a.m. During that timeframe, Subject [redacted] rose from her seat and walked down the hallway, performing room checks on other service recipients, then returned to her seated position. (Justice Center Exhibit 27: facility surveillance video recording of the shift)

15. At approximately 2:08 a.m., Subject [redacted] rose from her seat and walked up the hallway past Subject [redacted]. As Subject [redacted] walked by Subject [redacted], Subject [redacted] lifted her head, turned it toward the Service Recipient's room and looked into the Service Recipient's room while remaining seated. Approximately one

minute later, Subject [redacted] returned to her seat and resumed her seated position. Subject [redacted] rose again after a few seconds, walked over to the Service Recipient's doorway, leaned over Subject [redacted] and peered in the Service Recipient's room. At that point, Subject [redacted] leaned forward toward the Service Recipient and removed her sunglasses. (Justice Center Exhibit 27: facility surveillance video recording of the shift) Because Subject [redacted] saw blood on the Service Recipient's sheets and arm, she left the room to inform the nurse. (Justice Center Exhibits 17, 22 and 27: audio recording of Justice Center interrogation of Subject [redacted]; and Hearing testimony of Subject [redacted])

16. At approximately 2:22 a.m., [redacted], Registered Nurse 2 (RN1) and [redacted], Registered Nurse 2 (RN2) responded to the Service Recipient's room. When the nurses entered the Service Recipient's room, they found blood on the Service Recipient's left arm and mouth, and on her sheets. Upon examination of the Service Recipient, they found that the Service Recipient had removed the bandage and reopened the wound on her left arm with her mouth. The nurses cleaned and rebandaged the wound and, after instructing the Subjects to watch the Service Recipient so she did not reopen her wound again, they left the room. (Justice Center Exhibits 15, 17, 22 and 27: audio recording of Justice Center interviews of RN1 and RN2) At approximately 2:36 a.m., a facility doctor entered the Service Recipient's room and examined the Service Recipient's wound. (Justice Center Exhibits 15 and 27: audio recording of Justice Center interview of facility doctor)

17. At no time between 1:30 a.m. and 3:00 a.m. was Subject [redacted] within arm's length plus twelve inches of the Service Recipient. (Justice Center Exhibit 27: facility surveillance video of shift)

18. At approximately 3:52 a.m., Subject [redacted] rose from her chair and left

the vicinity of the Service Recipient's room. Subject [redacted] remained seated and pulled her chair within three feet and to the left of the Service Recipient's doorway where there was a wall between Subject [redacted] and the Service Recipient. Subject [redacted] head remained in a downward direction, not looking in the direction of Service Recipient until approximately 3:56 a.m., when Subject [redacted] returned with RN1 and RN2. RN1 and RN2 entered the Service Recipient's room and discovered that the Service Recipient had again removed the bandage from the wound on her left arm. RN1 and RN2 cleaned and rebandaged the Service Recipient's wound, and this time covered the bandage with tape, in an effort to make the bandage more secure. (Justice Center Exhibits 17, 22 and 27: audio recording of Justice Center interview of RN1, RN2 and senior SHTA, and facility surveillance video of shift)

19. From approximately 4:10 a.m. to 4:13 a.m., neither Subject [redacted] nor Subject [redacted] were looking in the direction of the Service Recipient. (Justice Center Exhibit 27: facility surveillance video of shift)

20. At approximately 4:57 a.m., Subject [redacted] rose from her chair and left the area in front on the Service Recipient's room, ending her 1:1 shift. Immediately thereafter, SHTA1 moved a chair in front of the Service Recipient's room and commenced her 1:1 supervision shift. From 4:57 a.m. until 7:00 a.m., SHTA1 performed 1:1 supervision of the Service Recipient. (Justice Center Exhibit 27: audio recording of Justice Center interrogation of SHTA1 and facility surveillance video of shift; and Hearing testimony of SHTA1)

21. After the 7:00 a.m. shift change, during a search of the Service Recipient by [redacted], Registered Nurse 4 (RN3), the day shift nurse, the Service Recipient told RN3 that she had reopened her wound and that she had been chewing on it all night. RN3 noticed dried blood around the wound and the Service Recipient's mouth. The wound was not actively bleeding.

RN3 reapplied the bandage to the Service Recipient's wound. (Justice Center Exhibits 17 and 27: audio recording of Justice Center interview of RN3)

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 neglect and abuse 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 neglect and abuse (obstruction of reports of reportable incidents) of a person in a facility or provider agency is defined by SSL § 488(1)(f) and (h), as follows:

> (f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who

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

Substantiated reports of neglect and abuse shall be categorized into categories pursuant to SSL § 493(4), including Category 2 and Category 3, which are defined as follows:

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

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

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

If the Justice Center did not prove the neglect and abuse 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 Subject [redacted] and Subject [redacted] committed an act, described as "Allegation 1" in the substantiated report. The Justice Center has not established by a preponderance of the evidence that Subject [redacted] committed an act, described as "Allegation 2" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents and photographs obtained during the investigation. (Justice Center Exhibits 1 through 26, 28 and 32) The Justice Center also presented audio recordings of the Justice Center Investigator's interview of witnesses and interrogation of the Subjects and SHTA1, and a facility surveillance video recording of the shift in question. (Justice Center Exhibit 27) The investigation underlying the substantiated report was conducted by [redacted], Justice Center Investigator (Investigator), who testified at the hearing on behalf of the Justice Center.

The Subjects and SHTA1 each testified in their own behalf and presented no other evidence.

Neglect

In order to prove neglect, the Justice Center must establish by a preponderance of the evidence that the Subjects' actions, inactions or lack of attention breached a duty that resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL § 488(1)(h))

The Justice Center contends that the Subjects had a duty to provide 1:1 supervision for the Service Recipient and that the Subjects breached this duty by falling asleep, being less than alert or otherwise not providing proper supervision. The Subjects both deny having fallen asleep, having been less than alert and having not provided proper supervision.

The Justice Center presented no direct evidence of the Subjects sleeping during the overnight shift starting on [redacted] at 11:00 p.m. and ending on [redacted] at 7:00 a.m. However, a review of the Justice Center's video provides sufficient evidence to conclude that the Subjects failed to provide the level of supervision required by facility policy.

It is not clear from the evidence in the record which SHTA was providing 1:1 supervision during Subject [redacted] assigned 1:1 shift from 1:00 a.m. to 1:30 a.m. However, for the remaining portion of Subject [redacted] 1:00 a.m. until 3:00 a.m. 1:1 shift, Subject [redacted] was not within arm's length plus twelve inches of the Service Recipient. Subject [redacted] argues that Subject [redacted] was providing the 1:1 supervision during this timeframe. In support of this claim, the record reflects that Subject [redacted] was stationed within arm's length plus twelve inches of the Service Recipient. However, during the timeframe of 1:42 a.m. until 2:08 a.m., approximately twenty-six minutes, Subject [redacted] was looking down and away from the Service Recipient and remained motionless. (Justice Center Exhibit 27: facility surveillance video recording of the shift) During this timeframe, Subject

[redacted] was not maintaining direct visual contact and Subject [redacted] was not within arm's length plus twelve inches. Neither Subject was in compliance with the requirements of facility policy. Consequently, both Subjects breached their duty to the Service Recipient.

Although impairment or likely impairment was not alleged by the Justice Center in its substantiation document, evidence in the hearing sufficiently established this element of neglect. Immediately following the Subjects' breach of duty, the Service Recipient was found to have harmed herself by removing the bandage and biting the wound on her left arm. The Subjects argue that they acted immediately upon seeing that the Service Recipient had removed her bandage. However, the record reflects that the Service Recipient was found with blood on her sheets, her arm and her mouth, indicating that she had done much more than remove her bandage and that she had spent much more time and effort than what it would take to simply remove her bandage. Even if the Subjects acted as quickly as they claim, nonetheless, the Subjects' breaches (Subject [redacted] failure to maintain direct visual contact and Subject [redacted] failure to remain within arm's length plus twelve inches) were likely to have resulted in the Service Recipient sustaining physical injury or serious or protracted impairment of her physical, mental or emotional condition.

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

Abuse (Obstruction of Reports of Reportable Incidents)

In order to prove abuse (obstruction of reports of reportable incidents) by falsifying records, as it was alleged in this report, the Justice Center must establish by a preponderance of the evidence that Subject [redacted] impeded the "... investigation of the treatment of a service

recipient by ... intentionally making a false statement." (SSL § 488(1)(f))

The Justice Center alleges that Subject [redacted] falsified records related to the Service Recipient's safety and supervision, specifically, that the Subject made entries in the Special Observation Levels and Restraint or Seclusion Monitoring Log (Log) when she was not providing 1:1 supervision of the Service Recipient.

The record reflects that Subject [redacted] made Service Recipient status entries in the Log at 12:45 a.m., 1:00 a.m., 1:15 a.m., 1:30 a.m., 1:45 a.m., 2:00 a.m., 2:10 a.m., 2:15 a.m., 2:45 a.m. and 3:00 a.m. (Justice Center Exhibit 22) The record also reflects that Subject [redacted] did not provide 1:1 supervision between 1:30 a.m. and 3:00 a.m. The record is not clear as to whether or not it is proper for a SHTA, other than the SHTA providing 1:1 supervision, to note the Service Recipient's status in the Log. The Justice Center also did not provide evidence that the Subject's conduct impeded the investigation of the treatment of the Service Recipient. When asked by the Administrative Law Judge how the entries made by Subject [redacted] impeded her investigation, the Investigator did not provide any evidence or information that it did. (Hearing testimony of the Investigator)

Accordingly, it is determined that the Justice Center has not met its burden of proving by a preponderance of the evidence that Subject [redacted] committed the abuse (obstruction of reports of reportable incidents) as alleged. The substantiated report, to the extent that it alleges abuse (obstruction of reports of reportable incidents), will be amended and sealed.

Although the report will remain substantiated for both Subjects, the next question to be decided is whether the substantiated report constitutes the category of abuse or neglect set forth in the substantiated report. Category 2 conduct is defined as conduct in which the Subjects seriously endangered the health, safety or welfare of the Service Recipient. (SSL § 493(4)(b)) The Subjects'

failure to do the one task that they were both specifically assigned to do, to maintain direct visual observation of the Service Recipient, taken together with the expressed reason for the 1:1 supervision, the Service Recipient's proclivity toward self-abuse, created a situation in which the Service Recipient was left to physically harm herself to the extent that she pleased. Consequently, the Subject's conduct seriously endangered the Service Recipient's health, safety and welfare. Based upon the totality of the circumstances and the evidence presented, it is determined that the substantiated report is properly categorized as a Category 2 act.

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

DECISION: The requests of [redacted] and [redacted], that the substantiated report dated [redacted] insofar as it alleged neglect be amended and sealed, is denied. The Subjects have been shown by a preponderance of the evidence to have committed neglect.

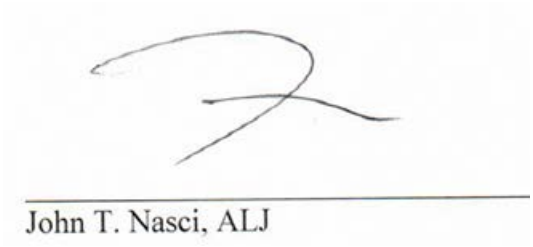
The substantiated report is properly categorized, as a Category 2 act.

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

evidence to have committed abuse (obstruction of reports of reportable incidents).

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

DATED: December 24, 2018
Schenectady, New York



John T. Nasci, ALJ