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 AFTER HEARING** **Adjud. 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]

[redacted]

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

ORDERED: The request of [redacted] that the substantiated report, dated [redacted], [redacted]; received and dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized, or should be categorized as a Category 2.

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

[redacted]

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: May 19, 2015
Schenectady, New York

David Molik
Administrative Hearings Unit

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

In the Matter of the Appeal of [redacted] Pursuant to § 494 of the Social Services Law	**RECOMMENDED DECISION AFTER HEARING** **Adjud. Case #:** [redacted]

Before: John T. Nasci
Administrative Law Judge

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

Parties: 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]

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, dated [redacted], [redacted], received and dated [redacted] of neglect by the Subject of a Service Recipient.

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

Offense 1

> It was alleged that on [redacted], on an outing to [redacted] from the [redacted], located at [redacted], while acting as a custodian (DSA) you committed neglect when you unstrapped a service recipient's wheelchair and left the van's door open, and left the service recipient unattended in the van for a short time, during which time she rolled out of the van in her wheelchair and fell onto the pavement, hitting her head and causing bleeding and injury.
>
> This allegation has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493.

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

4. [redacted] (the Facility), located at [redacted]

[redacted], is an [redacted], and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center. (See Justice Center Exhibit 4; and testimony of [redacted])

5. At the time of the alleged neglect, the Subject was employed by OPWDD at the Facility as a Habilitation Specialist 1, and had been employed at the Facility for approximately 12 years prior to the date of the hearing. (See Justice Center Exhibit 5 page 7)

6. At the time of the alleged neglect, the Service Recipient, who was the object of the Subject's alleged neglect, was 55 years of age, and had been a resident of the facility since approximately [redacted] 1996. The Service Recipient is an adult person with a diagnosis of profound mental retardation who is non-verbal, non-ambulatory and requires total assistance. (Justice Center Exhibits 20 and 21; and testimony of [redacted])

7. On or about [redacted], the Subject, along with two other staff (referred hereafter as Staff [redacted] and [redacted]), took the Service Recipient and two other clients (referred hereafter as Client A and Client B) in a service van equipped to handle the transportation of up to two or three wheelchair transported clients on an outing to [redacted] National Monument [redacted]. (See testimony of [redacted]; and testimony of the Subject)

8. The service van layout is described as follows. Located in the front of the service van are the driver seat and a separate passenger seat located on the opposite side of the service van from the driver seat. Behind the driver seat are two rows of bench type seats that are folded-up and stored against the driver side of the service van. Behind the front passenger seat are two rows of individual seats that correspond respectively to the folded-up bench type seats on the

opposite side of the service van. Between the folded-up bench seats and the single seats, on the floor in the center of the service van, is a set of tracks approximately eighteen inches apart that runs from behind the front seats to the rear of the service van. The portion of the service van containing the tracks is where wheelchair bound clients are positioned during transport and the tracks are used to secure the wheelchairs. The wheelchairs are secured to the tracks with a set of straps and hooks. The service van has a front driver door, a front passenger door, a second set of passenger side doors located behind the front passenger door and two rear doors. Within the second set of passenger side doors is a hydraulic lift that is used to move the wheelchair-bound clients in and out of the service van. The rear doors open from the center of the service van outward toward the sides of the service van and allow access to the entire rear interior of the service van. (See Justice Center Exhibits 16, 17 and 18; testimony of [redacted]; testimony of [redacted]; and testimony of the Subject)

9. The Facility's prescribed procedure for removing wheelchair clients from the service van when there is more than one staff present is as follows. Upon arrival, the driver park on a level surface and engages the service van's emergency brake. Engaging the emergency brake releases an interlock which prevents the lift from operating when the emergency brake is not engaged. Staff outside the service van then opens and secures the side doors and uses the lift controls to open the lift and place it in position to accept a client in a wheelchair. Staff inside the service van first removes the client's shoulder harness, then removes the front two floor straps and hooks from the wheelchair, then removes the rear two straps and hooks from the wheelchair, and then releases the wheelchair brakes. Once the wheelchair restraints and brakes are removed and released, staff then moves the wheelchair to the lift and secures the wheelchair to the lift. The staff positioned outside the service van then lowers the lift to the ground. After the client is

secure on the ground, staff inside the service van repeats the process for the next wheelchair client. A partially ambulatory client is removed from the service van last using the transport wheelchair and employing the same procedure. In the event the rear straps and/or wheelchair brakes are not reachable by staff from inside the service van, they may be removed and released from the rear of the service van in the same order and timing as described above. Staff should not release the wheelchair brakes until the wheelchair is ready to be moved to the lift. (See Justice Center Exhibit 14; and testimony of [redacted])

10. On the [redacted], outing the Subject drove the service van, Staff [redacted] rode in the front passenger seat, Staff [redacted] rode in the rear side seat, Client A rode in the middle side seat, Client B rode in a wheelchair in the middle center of the service van and the Service Recipient rode in her wheelchair in the rear center of the service van behind Client B. Client A was ambulatory but required the use of a transport wheelchair to move in and out of the service van. While in transit, the transport wheelchair was folded up and stored perpendicularly in the rear of the service van behind the Service Recipient's wheelchair. (See Justice Center Exhibit 26 containing audio recordings of interrogations of Staff [redacted] Staff [redacted] and the Subject; testimony of [redacted]; and testimony of the Subject)

11. Upon arrival at the parking lot located across [redacted] from the [redacted] National Monument, the Subject parked the service van on a slight incline with the rear of the service van lower than the front of the service van. After parking the service van, the Subject exited the vehicle without applying the service van's emergency parking brake and proceeded to the rear of the vehicle. The Subject then opened the service van's rear doors, reached around the folded-up transport wheelchair with both arms, removed the rear straps and hooks from the Service Recipient's wheelchair and released the brakes on the Service

Recipient's wheelchair. The Subject then removed the transport wheelchair from the rear of the service van, opened it up and set it to the side of the service van. At the same time as the Subject exited the service van, Staff [redacted] exited the service van, opened the side door and attempted to operate the lift, but found that it would not function because service van's emergency brake had not been engaged. Also at the same time as the Subject's exit from the service van, Staff [redacted] removed the front straps and hooks from the service recipient's wheelchair. Neither the Subject nor the other two staff communicated their actions to each other. When Staff [redacted] realized that the service van emergency brake was not engaged, she yelled to the Subject and Staff [redacted] that the brake was not applied. Staff [redacted] yelled back that she would take care of it. After the Subject removed the transport wheelchair from the rear of the service van and at approximately the same time that Staff [redacted] went to the driver seat to engage the service van emergency brake, the Service Recipient in her wheelchair rolled out the back of the service van and fell to the ground. Upon impact with the ground, the Service Recipient hit her head on the ground. (See Justice Center Exhibit 26 containing audio recordings of interrogations of Staff [redacted] Staff [redacted] and the Subject; and testimony of the Subject).

12. As a result of the incident, the Service Recipient sustained a laceration on her head that required emergency medical transportation to a hospital and treatment that included the use of five staples to close the wound. (See Justice Center Exhibits 23 and 24; and testimony of [redacted]).

13. The Subject received Vehicle Training/Wheelchair Securement training on [redacted]. (See Justice Center Exhibit 10)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of abuse and neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of evidence that the alleged act or acts of abuse 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, described in the substantiated report. The act committed by the Subject constitutes neglect. The category of the affirmed substantiated neglect that such act constitutes is Category 2.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation (Justice Center Exhibits 1-25) and audio recordings of the Justice Center investigator interrogations (Justice Center Exhibit 26). The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who at the time of the investigation and the substantiation was an OPWDD employee. [redacted] was one of three witnesses who testified at the hearing on behalf of the Justice Center. Also testifying for the Justice Center was [redacted], an Adaptive Equipment Operator at [redacted], of the OPWDD and [redacted], Program Manager at the [redacted], of the OPWDD, who is the Subject's supervisor.

The Subject testified on his own behalf and presented no exhibits.

The Justice Center proved by a fair preponderance of the evidence that the Subject committed neglect by removing the restraints from and releasing the brakes on the Service Recipient's wheelchair without communicating or coordinating his actions with the other staff, then turning his attention and body away from the Service Recipient long enough for the Service

Recipient to roll out the rear of the service van in her wheelchair, fall to the ground, hit her head and sustain a severe laceration.

There is no substantial disagreement concerning the facts. The Justice Center contends that the Subject failed to follow the established procedure for which he was trained, and that the Subject's failure to follow the procedure resulted in the Service Recipient sustaining physical injuries. The Subject contends that the incident was an accident. However, he admitted that the incident could have been prevented if he had not released the wheelchair brakes. (See Justice Center Exhibit 26: audio recording of interrogation of the Subject)

The record reflects that the Justice Center's witness [redacted] is an employee of [redacted] and holds the position of Adaptive Equipment Coordinator, and that [redacted] is responsible for training employees such as the Subject in procedures for the vehicular transportation of clients, including the proper procedure for the use of wheelchair restraints and the wheelchair lift mechanism. (See testimony of [redacted]) The record reflects that the procedure employed by the Subject and the other staff did not follow the procedure described by [redacted]. Specifically, and critical to this instance, the Subject removed the rear straps and released the brakes on the Service Recipient's wheelchair immediately after parking the service van, without determining whether or not the Service Recipient was ready to be moved from the service van. In accordance with the procedure described by [redacted], the rear straps of the Service Recipient's wheelchair should not have been removed until after the other two clients had been safely removed from the service van. Because the Service Recipient was located in the rear of the service van, she would have been the last client to be removed from the service van and her wheelchair should have remained strapped down with the wheelchair brakes applied until the other two clients were removed from

the service van. Additionally, the Service Recipient's brakes should not have been released until the Service Recipient was ready to be moved. The record reflects that neither of the other two clients were removed from the service van or even ready to be removed from the service van.

The Subject explained in his testimony that he removed the rear straps and released the wheelchair brakes when he did, from the rear of the service van, because neither the straps nor the brakes were reachable from inside the service van, and that he did this to save time. (See testimony of the Subject) However, this explanation does not mitigate the Subject's culpability in his failure to follow the proper procedure, which directly resulted in a foreseeable and preventable injury to a client who was in his direct care. The Subject admitted in his testimony that he did not know whether or not the staff in the service van had removed the front straps to the Service Recipient's wheelchair and what the other two staff were doing. (*ibid*) Had the Subject communicated with the other two staff and waited for all other clients to be removed from the service van, the Service Recipient would not have been injured.

Furthermore, the Subject testified that he parked the service van in a parking lot with a sloped surface, and that the rear of the service van was positioned on the parking lot lower in elevation than the front of the service van. Common sense would dictate the application of an extra degree of care in the handling of wheelchair bound clients when parking on a non-level surface. However, there is no evidence in the record that the Subject took into consideration the slope of the parking lot. To the contrary, the Subject's failure to engage the service van parking brake indicates that he did not consider the slope of the parking lot. Consequently, the Subject's choice of parking location and his failure to factor in the slope of the parking lot contributed to the cause of the wheelchair's exit from the service van and the resultant injuries to the Service Recipient.

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

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. It is concluded that this report is properly categorized as a Category 2 neglect.

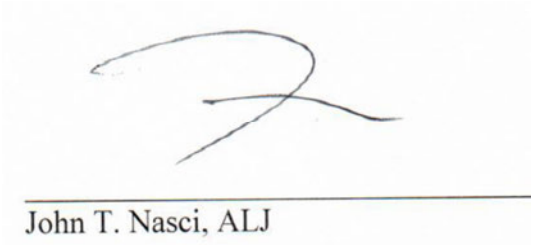
Category 2 conduct shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that such custodian engaged in Category 2 conduct. Reports that result in a Category two finding not elevated to a Category one finding shall be sealed after five years.

DECISION: The request of [redacted] that the substantiated report, dated [redacted], [redacted]; received and dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized, or should be categorized as a Category 2.

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

DATED: April 24, 2015
Schenectady, New York



John T. Nasci, ALJ