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: Robert DeCataldo, Esq.

[redacted]
By: William A. Gerard, Esq.
71 Woods Road
P.O. Box 717
Palisades, New York 10964

[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] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed abuse and neglect.

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

NOW, THEREFORE, IT IS DETERMINED that reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years. The record of these reports shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(b).

[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: September 1, 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

Adjud. Case #: [redacted]

Before: Louis Renzi
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
11 Perlman Drive
Spring Valley, New York 10977
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
Appearance Waived

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JURISDICTION

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

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

Allegation 1

It was alleged that on [redacted] at the [redacted], located at [redacted] while acting as a custodian, you committed physical abuse and/or neglect when you dragged a service recipient (who has been diagnosed with severe degenerative disc disease) by his ankles during a fire drill.

These allegations have been SUBSTANTIATED as Category 2 physical abuse and Category 2 neglect, pursuant to Social Services Law § 493(4)(b).

Allegation 2

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) when you dragged a service recipient (who has been diagnosed with severe degenerative disc disease) by his ankles during a fire drill.

This allegation has been SUBSTANTIATED as Category 2 abuse (deliberate inappropriate use of restraints), pursuant to Social Services Law § 493(4)(b).

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

4. The facility, [redacted], located at [redacted], is a group home housing six adult males with developmental disabilities. The facility is operated by the [redacted], which is part of the New York State Office of People With Developmental Disabilities (OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of [redacted])

5. At the time of the alleged abuse and neglect, the Subject was employed by [redacted] as a Direct Support Assistant (DSA) and had been employed by the [redacted] for thirty-one years. (Justice Center Exhibit 20)

6. At the time of the alleged abuse and neglect, the Service Recipient was sixty-seven years old, and had been a resident of the facility for approximately three years. The Service Recipient was an adult male with a developmental diagnosis of severe range of mental retardation. The Service Recipient was non-verbal but understood when spoken to. The Service Recipient was ambulatory but unsteady at times. The Service Recipient frequently urinated on himself. The Service Recipient stood approximately 6 feet 3 inches tall. (Subject Exhibit A, Justice Center Exhibit 7, 20)

7. The Service Recipient was also diagnosed with severe degenerative disk disease throughout his cervical spine on [redacted] and, as a result, he was recommended to forgo climbing stairs. To adhere to the recommendation, in [redacted], the Service Recipient was moved to the [redacted] where his bedroom was located on the first floor. (Justice

Center Exhibit 7, Hearing testimony of [redacted])

8. On [redacted] the Subject and Staff [redacted] worked the night shift at the [redacted]. [redacted] Developmental Assistant 3 (DA3) was also present at the [redacted] for the purpose of conducting a fire drill. Prior to the commencement of the fire drill, [redacted], Staff [redacted] and the Subject discussed the details of the fire drill and assigned staff responsibilities as follows: Staff [redacted] would evacuate service recipient A and B who were in a wheelchair and blind respectively, and who were sleeping in bedrooms that were located closest to the exit; and the Subject would evacuate the remaining four service recipients who required various levels of prompting but were ambulatory and could exit with minimal assistance. (Justice Center Exhibit 20, Hearing testimony of [redacted])

9. At approximately 1:40 a.m., [redacted] commenced the fire drill by pressing a button on a smoke detector located on the kitchen ceiling of the [redacted] Staff [redacted] proceeded to evacuate service recipients A and B. When the Subject attempted to rouse the Service Recipient from his bed, he refused get up. The Subject successfully evacuated service recipients C, D and E, and when he returned to evacuate the Service Recipient, he found the Service Recipient sitting on the bedroom floor. (Justice Center Exhibit 20, Hearing testimony of [redacted]

10. After attempting unsuccessfully to verbally prompt the Service Recipient to stand up, the Subject dragged the Service Recipient by his ankles, and on his back, from the Service Recipient's bedroom, down the hallway, to the intersection between the hallway, the kitchen and the living room. When the Subject reached the intersection, [redacted] who was standing in the kitchen, observed the Subject dragging the Service Recipient and instructed the Subject to stop. The Subject then dragged the Service Recipient into the living room and let go of the Service Recipient's ankles. The total distance that the Subject dragged the Service Recipient was

approximately forty-five feet. (Justice Center Exhibit 20, Hearing testimony of [redacted])

11. [redacted] then instructed Staff [redacted] to help the Subject get the Service Recipient up off the floor and out of the house. After unsuccessfully attempting to help the Service Recipient lift himself up using a nearby chair, Staff [redacted] and the Subject each grabbed the Service Recipient by one of the Service Recipient's armpits, lifted him and moved him through the front door outside to the deck, where they let go of the Service Recipient and left him sitting on the deck. (Justice Center Exhibit 20, Hearing testimony of [redacted])

12. Once the Service Recipient was outside the house, [redacted] declared the fire drill complete and successful, and then instructed the Subject and Staff [redacted] to return the service recipients to their bedrooms. Thereafter, the Subject and Staff [redacted] lifted the Service Recipient by his armpits, as they had done to evacuate the Service Recipient from the house, and returned him inside the house, where they placed him down sitting on the living room floor. At that point, they noticed that the Service Recipient had urinated on himself. The Subject, on the instructions of [redacted], then then took the Service Recipient to the shower to be cleaned. (Justice Center Exhibit 20, Hearing testimony of [redacted])

13. While the Service Recipient was in the shower, [redacted] conducted a body check of the Service Recipient and noticed three abrasions: on the center of the back, approximately one inch wide by two inches long; on the upper back, approximately two inches wide by one half inch long; and on the chest under the right arm, approximately two inches wide by two inches long. After the shower was complete, the Service Recipient was returned to his bed where [redacted] made a record of the abrasions by taking digital photographs and recording a video. (Justice Center Exhibits 18, 20, 42A-42E, Hearing testimony of [redacted])

14. The Service Recipient's bedroom, the hallway and the living room all contained

finished wood floors. The kitchen floor was tiled. The floors of the hallway and the kitchen were connected by a wood threshold and a metal strip secured with nails. The floors of the kitchen and the living room were connected by a wood threshold. Both wood thresholds were approximately six inches in width and three quarters inch higher than the floors. (Justice Center Exhibits 22, 23, 25-32, 34-39, 41, Hearing testimony of Justice Center Investigator [redacted])

15. Being dragged in a supine position by the Subject exposed the Service Recipient's cervical spine to further injury. (Justice Center Exhibit 6, Hearing testimony of Justice Center Investigator [redacted]

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 physical abuse, abuse (deliberate inappropriate use of restraints, 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 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) (a), (d) and (h), to include:

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

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4)(b), including Category (2), which is 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.

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

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

If the Justice Center did not prove the abuse and 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 an act, described as "Allegation 1" and "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 1-32, 34- 39, 41-43) The Justice Center also presented audio recordings of the Justice Center Investigator's interview

of witnesses and interrogation of the Subject, and a video of the Service Recipient's injuries. (Justice Center Exhibit 20) The investigation underlying the substantiated report was conducted by Justice Center Investigator [redacted], who testified at the hearing on behalf of the Justice Center. DA3 [redacted] also testified on behalf of the Justice Center.

The Subject presented an audio recording of the Justice Center hotline telephone call that initiated the report, one document and one witness who testified on his behalf. (Subject Exhibits A, B, Hearing testimony of [redacted] The Subject did not testify in his own behalf.

The facts relevant to the issues in this hearing are mostly undisputed. The Subject dragged the Service Recipient by the Service Recipient's ankles, with the Service Recipient on his back, down a wood floored hallway, over a raised wooden threshold to a tiled kitchen, and over a second raised wooden threshold to the wood floored living room, traveling a total distance of approximately forty-five feet.

Allegation 1 – Physical Abuse

The Justice Center proved by a preponderance of the evidence not only that the Subject recklessly caused the likelihood of serious impairment of the Service Recipient's physical condition, but also that the Subject recklessly caused actual physical injury to the Service Recipient by dragging the Service Recipient by the Service Recipient's ankles.

In order to prove physical abuse, the Justice Center must establish by a preponderance of the evidence that the Subject intentionally or recklessly caused, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or caused the likelihood of such injury or impairment. (SSL §488(1)(a))

While the record does not contain evidence that the Subject intended to cause physical injury to the Service Recipient, the record does support a finding that the Subject's conduct was

reckless. The term "reckless" as used in the statute is defined by Penal Law as:

> A person acts recklessly with respect to a result ... when he is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur ... The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation.

(SSL §488(16) and Penal Law §15.05(3))

As part of his employment duties as a DSA, the Subject was expected to read and be familiar with the Service Recipient's Individualized Service Plan (ISP) which was kept in the [redacted] and which contained information concerning the Service Recipient's diagnoses, among other things. (Hearing testimony of [redacted] The Subject stated that he did, in fact, read the Service Recipient's ISP. (Justice Center Exhibit 20) The ISP contains information concerning the Service Recipient's diagnosis of degenerative disk disease. Therefore, the Subject was aware or should have been aware that the Service Recipient was diagnosed with degenerative disk disease in his cervical spine.

Additionally, the Subject was aware or should have been aware that dragging the Service Recipient on his back would place the Service Recipient at risk of further injury to his spinal condition. The record reflects that dragging the Service Recipient in a supine position "exposed his already compromised cervical spine to further injury." (Justice Center Exhibit 6, Hearing testimony of Justice Center Investigator [redacted] Because injury to the Service Recipient's spine could result in pain and/or lead to paralysis, the risk to the Service Recipient was substantial. In addition, "dragging" is one of the enumerated examples of physically abusive conduct noted in SSL 488(1)(a).

As a DSA, the Subject had at his disposal, and knew or should have known about, an approved method for evacuating a non-cooperating service recipient. In the event a service

recipient refused to evacuate voluntarily, the DSAs were allowed to put that service recipient in a sheet or blanket and carry or pull the service recipient out of the house. (Justice Center Exhibit 20) Because the Subject had a sanctioned method for evacuating an uncooperative service recipient at his disposal, the risk that the Subject placed the Service Recipient in by dragging him by his feet on his back was unjustifiable.

Finally, the record reflects that the Subject could have easily employed the approved method of evacuation by pulling a sheet or blanket off the bed, placing the Service Recipient in the sheet or blanket on the floor, and pulling the Service Recipient down the hall and out of the house; further, he could have achieved this within the timeframe required to complete the fire drill. With foreknowledge of the approved evacuation method and the Service Recipient's spinal condition, the Subject's conduct constituted a gross deviation from the conduct of a reasonable person in the Subject's position.

In response to the Subject's claim in his own defense, the Justice Center must also establish that the evacuation method used by the Subject was not a reasonable emergency intervention necessary to protect the safety of any person. (SSL §488(1)(a)) Although the Subject's conduct took place during a fire drill in which the Subject and other staff were told to act as if a real fire was taking place, there was no actual fire or actual emergency requiring action to be taken in order to protect the safety of anyone. The record reflects that, in the event staff is not able to evacuate a service recipient within the allotted time frame, there would be no consequences other than staff's participation in a discussion to determine how better to evacuate the service recipients and another attempt at a successful fire drill. (Hearing testimony of [redacted])

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 physical abuse alleged in Allegation

1. 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 abuse or neglect set forth in the substantiated report. The report was substantiated a Category 2 physical abuse. To prove Category 2 conduct, the Justice Center must establish that Subject's conduct "seriously endanger[ed] the health, safety or welfare of [the] Service Recipient …" (SSL §493(4)(b)) The record reflects that dragging the Service Recipient in a supine position "exposed his already compromised cervical spine to further injury." (Justice Center Exhibit 6, Hearing testimony of Justice Center Investigator [redacted] Because injury to the Service Recipient's spine could result in pain and/or lead to paralysis, it is determined that the Subject's conduct seriously endangered the Service Recipient's health. Consequently, it is determined that the substantiated report is properly categorized as a Category 2 act.

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 2 finding not elevated to a Category 1 finding shall be sealed after five years.

Allegation 1 – Neglect

The Justice Center proved by a preponderance of the evidence that the Subject breached his duty to the Service Recipient by using an unapproved method to evacuate the Service Recipient during a fire drill, and that the Subject's breach resulted in physical injury to the Service Recipient, and likely resulted in serious and/or protracted impairment to the Service Recipient's physical condition.

In order to prove neglect, the Justice Center must establish by a preponderance of the

evidence that the Subject breached his custodian's duty to the Service Recipient and that the breach 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 record reflects that the Subject dragged the Service Recipient by his ankles and on his back, a distance of approximately forty-five feet. The record also reflects that dragging a service recipient from the house during a fire drill is not an approved method of evacuation. Therefore, the Subject breached his duty to the Service Recipient.

The record also reflects that the Service Recipient suffered physical injuries as a result of being dragged by the Subject, namely, three abrasions on the subject's back and side. Finally the record reflects that the Subject's conduct exposed the Service Recipient to further injury of his cervical spine, having been diagnosed with degenerative disk disease, and that further injury to the Service Recipient's cervical spine could result in pain and/or lead to paralysis.

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 neglect alleged in Allegation 1. 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 abuse or neglect set forth in the substantiated report. The report was substantiated a Category 2 neglect. To prove Category 2 conduct, the Justice Center must establish that Subject's conduct "seriously endanger[ed] the health, safety or welfare of [the] Service Recipient …" (SSL §493(4)(b)) The record reflects that dragging the Service Recipient in a supine position "exposed his already compromised cervical spine to further injury." (Justice Center Exhibit 6 and Hearing testimony of Justice Center Investigator [redacted] Because injury to the Service Recipient's spine could result in pain and/or lead to

paralysis, it is determined that the Subject's conduct seriously endangered the Service Recipient's health. Consequently, it is determined that the substantiated report is properly categorized as a Category 2 act.

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 2 finding not elevated to a Category 1 finding shall be sealed after five years.

Allegation 2 – Abuse (Deliberate Inappropriate Use of Restraints)

The Justice Center proved by a preponderance of the evidence that the Subject deliberately used an unapproved restraint on the Service Recipient.

In order to prove abuse (deliberate inappropriate use of restraints), the Justice Center must first establish that the Subject used a restraint on the Service Recipient. The term "restraint" is defined as: "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." (SSL §488(1)(d)) By grasping the Service Recipient's ankles and pulling him on his back along a wooden floor, the Subject used a manual measure which limited the Service Recipient's ability to freely move his legs and body. Therefore, the Subject's conduct constitutes a restraint.

The Justice Center must next establish that Subject's restraint technique was deliberately inconsistent with the Service Recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies. (SSL §488(1)(d)) The Subject's conduct was neither sanctioned in the Service Recipient's Individualized Service Plan (ISP), Plan of Protective Oversight (PPO) or Behavior

Plan (BP), nor was it a method of restraint or evacuation approved by the facility or agency. (Justice Center Exhibits 7, 8, 9)

Again, in response to the Subject's claim in his own defense, the Justice Center must establish that the restraint used by the Subject was not used as a reasonable emergency intervention necessary to prevent imminent risk of harm to a person receiving services or to any other person. (SSL §488(1)(d)) Although the Subject's conduct took place during a fire drill in which the Subject and other staff were told to act as if a real fire was taking place, there was no actual fire or actual emergency requiring action to be taken in order to prevent imminent risk of harm to anyone. The record reflects that, in the event staff is not able to evacuate a service recipient within the allotted time frame, there would be no consequences other than staff's participation in a discussion to determine how better to evacuate the service recipients and another attempt at a successful fire drill. (Hearing testimony of [redacted])

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 abuse (deliberate inappropriate use of restraints) alleged in Allegation 2. 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 abuse or neglect set forth in the substantiated report. The report was substantiated a Category 2 abuse (deliberate inappropriate use of restraints). To prove Category 2 conduct, the Justice Center must establish that Subject's conduct "seriously endanger[ed] the health, safety or welfare of [the] Service Recipient …" (SSL §493(4)(b)) The record reflects that dragging the Service Recipient in a supine position "exposed his already compromised cervical spine to further injury." (Justice Center Exhibit 6 and Hearing testimony of Justice Center Investigator [redacted]) Because injury to the Service Recipient's spine

could result in pain and/or lead to paralysis, it is determined that the Subject's conduct seriously endangered the Service Recipient's health. Consequently, it is determined that the substantiated report is properly categorized as a Category 2 act.

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 2 finding not elevated to a Category 1 finding shall be sealed after five years.

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

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

This decision is recommended by Louis P. Renzi, Administrative Hearings Unit.

DATED: August 24, 2016
Schenectady, New York

Louis P. Renzi, ALJ