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: Jennifer Oppong, Esq.

[redacted]
By: William Lorman, Esq.
123 Guy Park Avenue
Amsterdam, New York 12010

[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 Allegation 1 of 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 neglect.

Allegation 1 of the substantiated report is properly categorized, as a Category 3 act.

The request of [redacted] that Allegation 2 of 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 (obstruction of reports of reportable incidents).

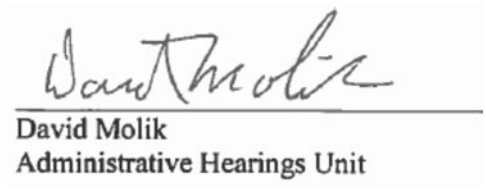
Allegation 2 of the substantiated report is properly categorized, as a Category 3 act.

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

[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 26, 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: Elizabeth M. Devane
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: 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
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By: Jennifer Oppong, Esq.

[redacted]

By: William Lorman, Esq.
123 Guy Park Avenue
Amsterdam, New York 12010

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for neglect and abuse (obstruction or reports of reportable incidents). The Subject requested that the VPCR amend the findings of the report to reflect that the Subject has not committed the acts of neglect and abuse giving rise to the substantiated report. The VPCR did not do so, and a hearing was 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] of neglect and abuse (obstruction of reports of reportable incidents) 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 neglect when you failed to ensure that a service recipient received medical attention after an allegation that he had been punched in the head by another staff member, and when you permitted that staff member to return to work.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

Allegation 2

It was alleged that on [redacted], at the [redacted] located at [redacted] while acting as a custodian, you committed abuse (obstruction of reports of reportable incidents) when you failed to

report or properly document an allegation of physical abuse against a service recipient.

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

3. An Administrative Review was conducted at the request of the Subject and following that review, the substantiated report was retained.

4. The facility, located at [redacted] is an [redacted] operated by [redacted], [redacted], which in turn is an agency certified by the Office for People With Developmental Disabilities (OPWDD). OPWDD is a provider agency that is subject to the jurisdiction of the Justice Center. [redacted] is a 24-hour staffed residence and provides supervision and services to residents who have varying degrees of behavioral support needs and assistance with activities of daily life. At the time of the alleged neglect and abuse there were four residents at [redacted] (Hearing testimony of Justice Center Investigator II [redacted] Hearing testimony of Subject and Justice Center Exhibits 5 and 15)

5. At the time of the alleged neglect and abuse, the Subject had been employed by [redacted] for almost 20 years and was employed as a Program Manager. The Subject was responsible for the general oversight of the [redacted], which included duties such as managing residences and day programs, budgeting and staffing. The Subject is a custodian as that term is defined in Social Services Law §488(2). (Hearing testimony of Justice Center Investigator II [redacted] Hearing testimony of Subject and Justice Center Exhibits 5 and 27)

6. [redacted] reporting procedures, effective since 2007 and titled "Consumer Abuse, Treatment, and Neglect", state that inflicting, or allowing to be inflicted, any pain or discomfort upon a service recipient is defined as abuse. Employees are responsible for reporting any incident

involving abuse of service recipients to their immediate supervisor. "Failure to report a suspicion of and/or an incident of abuse constitutes neglect". (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibit 16)

7. [redacted] employees must follow certain procedures under Part 624 of the New York Codes, Rules and Regulations (NYCRR) when reporting incidents of abuse of persons receiving services through OPWDD. Minor occurrences, such as challenging behavior or an illness not requiring a physician's care, must be documented electronically in a "T-Log" in the electronic system called "Therap". Discovery of an event that poses a health or safety risk, including an injury, must be reported in the General Events Record (GER). The completion of Antecedent, Behavior and Consequence (ABC) Behavioral Observation Forms, is also required when a behavior problem occurs. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 10 and 17)

8. The Incident Reporting and Abuse Regarding Consumer/Program Participant policy requires that mandated reporters call the Vulnerable Persons' Central Register (VPCR) immediately if they have reasonable suspicion that abuse, neglect or any harm has occurred to a service recipient. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibit 17)

9. At the time of the alleged neglect and abuse, the Service Recipient was 32 years old and had been a resident of the [redacted] for eleven years. The Service Recipient had multiple diagnoses including autism and mood regulation disorder, and he functioned in the moderate range of intellectual disabilities. The Service Recipient's cognition and communication skills were limited. (Hearing testimony of Justice Center Investigator II [redacted] Hearing testimony of Subject and Justice Center Exhibits 5, 12, 13, 14 and 18)

10. During waking hours, the [redacted] was required to have four staff on duty. The [redacted] was also required to have a minimum of two staff on duty trained in Strategies for Crisis Intervention and Prevention – Revised (SCIP-R) as directed by the Service Recipient's behavioral support plan and IPOP. (Hearing testimony of Justice Center Investigator II [redacted] Hearing testimony of Subject and Justice Center Exhibits 9, 15 and 18).

11. At the time of the alleged neglect and abuse, [redacted] between 4:00 p.m. and 5:00 p.m., three staff were on duty at the [redacted], only one of whom was SCIP-R trained. The fourth employee left around 4:00 p.m., before the end of her shift, resulting in the [redacted] being understaffed. The Subject became aware of this staffing issue earlier that afternoon, but was unsuccessful in her attempts to obtain coverage. The Subject told the Assistant Manager on duty that she would come to [redacted] to work if she was needed. (Hearing testimony of Justice Center Investigator II [redacted] Hearing testimony of Subject and Justice Center Exhibits 5, 21 and 26)

12. Between 4:00 p.m. and 5:00 p.m. on [redacted] staff began serving dinner to the service recipients. The Service Recipient had difficulty transitioning to the table to eat his meal, as was often the case. Several times, the Assistant Manager prompted the Service Recipient to eat and the Service Recipient became increasingly agitated. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5, 14, 18 and 26)

13. The Service Recipient then left the kitchen and went into the adjacent living room followed by the Assistant Manager. Staff Person A heard the Assistant Manager and Service Recipient yelling at one another, and what sounded like objects being thrown. The Assistant Manager called Staff Person A for assistance. Staff Person A entered the living room and saw pillows, a trash can and other items on the floor. The Service Recipient was sitting on the couch

and became calm immediately upon seeing Staff Person A. Staff Person A left the living room and returned to the kitchen and the service recipient she was supervising. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5, 14, 18 and 26)

14. A few minutes later, the Assistant Manager called Staff Person A back into the living room. When Staff Person A entered the living room, she saw the Assistant Manager crying and holding her bleeding hand in the air. She also saw that the Service Recipient was still seated on the couch. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5 and 26)

15. As a result of the incident, the Subject was called into the [redacted] and arrived there at approximately 5:30 p.m. After the Subject and Assistant Manager discussed the incident, the Subject sent the Assistant Manager to the hospital Emergency Room. (Hearing testimony of Justice Center Investigator II [redacted], Hearing testimony of Subject and Justice Center Exhibit 5, 21, 26 and 27)

16. The Assistant Manager was diagnosed at the hospital with a fracture of the fifth metacarpal bone in and an abrasion on her right hand. This type of fracture, also known as a "Boxer's Fracture, is often the result of a person striking an object with a closed fist. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5, 19 and 23)

17. The Assistant Manager telephoned Staff Person B between 7:00 p.m. and 7:30 p.m. on [redacted] while she was at the Emergency Room. The Assistant Manager told Staff Person B that she would be out of work for a while because her hand was broken. Staff Person B asked the Assistant Manager how she had broken her hand and the Assistant Manager stated that she punched the Service Recipient in the head. During the same conversation, the Assistant Manager said that the Service Recipient would not eat and that she followed him into the living

room where she straddled the Service Recipient and punched him in the head. The Assistant Manager then stated that she had been given morphine for her pain. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5 and 26)

18. The next day, [redacted], when the Subject arrived to work at 9:00 a.m., Staff Person B reported to the Subject the details of her phone conversation with the Assistant Manager the evening before. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5 and 26)

19. The Subject completed a Staff Incident Report and Investigation (Report) on [redacted] for the Assistant Manager, as the Assistant Manager could not do so herself as a result of her injury. In the report, the Subject wrote that the Assistant Manager's right hand was injured when she was blocking objects that were thrown at her by the Service Recipient. The Subject identified the possible objects causing injury as "note book computer, remotes, books, consumer head." (Hearing testimony of Justice Center Investigator II [redacted], Hearing testimony of Subject and Justice Center Exhibits 5, 23 and 26).

20. The Assistant Manager was out of work on disability due to the injury to her hand from [redacted] until approximately [redacted] when she received clearance to return to work. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5, 26 and 27)

21. On [redacted], Staff Person B overheard a telephone conversation between the Subject and the Assistant Manager, in which the Assistant Manager stated that she punched the Service Recipient in the head. During the conversation, the Subject said that she covered for the Assistant Manager and wrote on the forms exactly what the Assistant Manager told her. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5

and 26)

22. A report of abuse by the Assistant Manager and neglect and abuse by the Subject of the Service Recipient was called into the VPCR on [redacted]. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibit 5, 6 and 26)

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 neglect.
- Pursuant to Social Services Law § 493(4), the category of 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 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). Neglect under SSL § 488 (1) (h) is defined as:

> "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 abuse of a person in a facility or provider agency is defined by Social Services Law § 488 (1) (f) to include:

> "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.

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

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

In this matter, the Justice Center has the burden of proving by a preponderance of the evidence that the Subject committed the act(s) of neglect and abuse alleged in the substantiated report that is the subject of the proceeding and that such act(s) constitutes 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(s) 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 does 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 the Subject committed the act of neglect described as "Allegation 1" in the substantiated report. The Justice Center has also established by a preponderance of the evidence that the Subject committed the act of abuse described as "Allegation 2" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents, as well as video and audio interviews obtained during the investigation. (Justice Center Exhibits 1 - 28) Justice Center Investigator II [redacted] testified regarding the investigation underlying the substantiated report. She was the only witness who testified at the hearing on behalf of the Justice Center.

The Subject testified in her own behalf and did not present any documents.

Neglect

To prove neglect, the Justice Center must establish conduct by the Subject that breaches the Subject's custodian's duty to the Service Recipient and results in, or is likely to result in, physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. In this matter, the evidence establishes that the Subject failed to obtain medical attention for the Service Recipient and permitted the Assistant Manager to return to work after becoming aware of an allegation that the Assistant Manager punched the Service Recipient in the head. The Subject's conduct constitutes a breach of her custodian's duties.

The Subject argued at the hearing that the reason she did not seek medical treatment for the Service Recipient and did not oppose the Assistant Manager returning to work was that she had no knowledge that the Assistant Manager actually punched the Service Recipient. The Subject explained that, while she was told that the Assistant Manager admitted that she punched the Service Recipient, the Subject took this as a joke or as the result of pain relievers taken by the Assistant Manager at the time she made the statement. These arguments fail for lack of credibility.

When the Subject arrived at work the next morning, [redacted], Staff Person B immediately reported to the Subject the details of her phone conversation with the Assistant Manager the prior evening. Staff Person B told the Subject that the Assistant Manager said her hand was injured when she punched the Service Recipient in the head. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5 and 26)

Later that same day, the Subject wrote in the Report that the Assistant Manager sustained her hand injury at least partially due to contact with the Service Recipient's head. The Subject testified that she did not know why, or could not remember why, she wrote "consumer head" on the report. During her videotaped interview with Justice Center Investigator II [redacted] the Subject said that, at some point, the Assistant Manager said she may have had contact with the Service Recipient's head. During that interview, the Subject also stated the Assistant Manager told her that her hand injury resulted from her attempt to block a computer that the Service Recipient threw at her. The Subject stated that she saw that the computer was broken and saw plastic pieces of the computer on the ground in the living room. A record search of the electronic system [redacted] used to report issues with equipment, including notebook computers, by Justice Center Investigator II [redacted] did not find any reports of damage to that particular computer. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5

and 27) The Subject's statements are inconsistent and, in any event, show that the day after the incident she was aware of contact between the Subject's hand and the Service Recipient's head.

In the Report, the Subject wrote that Staff Person A went into the living room only one time, after the Service Recipient charged at the Assistant Manager and after the Assistant Manager had been injured. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibit 23) However, Staff Person A's version of events differs from the Subject's version. Staff Person A stated the she heard yelling and objects being thrown, coming from the living room. She also stated that she was called into the living room twice by the Assistant Manager. The first time she went into the living room, she observed that the Service Recipient was seated on the couch, had calmed immediately upon seeing her and indicated that he was ready to eat. Staff Person A then left the room. About three minutes later, Staff Person A was summoned again by the Assistant Manager and returned to the living room. This time, the Assistant Manager was crying and holding her hand. The Service Recipient was seated at the same spot on the couch. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5 and 26) There is no evidence in the record to support the conclusion that Staff Person A fabricated her account of the events and therefore her statement is credited evidence.

Additionally, the record reflects that the Service Recipient has a history of self-injury, but no history of attacking staff. The record also reflects that the Service Recipient also has a history of throwing objects, but not throwing objects at people. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5, 18, 26 and 27)

The type of fracture to the Assistant Manager's hand is commonly called a "Boxer's Fracture" as it is frequently caused by striking an object with a closed fist. The type of fracture, along with the bleeding around her knuckles, are not consistent with the description of blocking a

computer in a protective manner. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5, 6, 19 and 26)

Three months later, when the Assistant Manager admitted to the Subject that she punched the Service Recipient, the Subject still took no action to protect the Service Recipient. Instead, the Subject allowed the Assistant Manager to return to work, thereby disregarding the Service Recipient's safety.

On the date in question, the Assistant Manager's hand was broken and her knuckles were bleeding. The Subject was told by Staff Person A that the Assistant Manager admitted to punching the Service Recipient. The Subject herself used the term "consumer head" as an object causing injury in the report. The Subject had a duty at the time to determine, or at least investigate, if medical attention for the Service Recipient was necessary. The Subject's dismissal of the information as a joke or a side effect of pain relievers is a breach of the Subject's duty. The Subject also breached this duty by permitting the Assistant Manager to return to work without making a report or taking any other action. A punch to the head is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Despite the circumstances, the Subject failed to obtain medical attention for the Service Recipient and further allowed the potential for the Assistant Manager, who punched the Service Recipient in the head, to again have contact with the Service Recipient. The Subject's breach of duty was likely to result in physical injury or serious or protracted impairment to the physical, mental or emotional condition of the Service Recipient.

Abuse (Obstruction of reports or reportable incidents)

In order to prove Abuse (obstruction of reports of reportable incidents), based on a failure to report a reportable incident upon discovery, under Social Services Law § 488(1)(f), the Justice

Center must establish by a preponderance of evidence that the Subject is a mandated reporter who is a custodian, and that the Subject failed to report a reportable incident upon discovery. Reportable incidents pursuant to Social Services Law 488(1)(a –i) range from various types of abuse and neglect to "significant incidents" which include acts not rising to the level of abuse or neglect.

The uncontroverted evidence in the record establishes that the Subject is a custodian and, as a result, she is a mandated reporter. (Hearing testimony of Justice Center Investigator II [redacted] [redacted] Hearing testimony of Subject and Justice Center Exhibits 5, 16 and 17) Pursuant to Social Services Law § 491, a mandated reporter is required to report allegations of reportable incidents to the VPCR immediately upon discovery. Discovery occurs when the suspected reportable incident is witnessed by the mandated reporter, or when the mandated reporter is provided with reasonable cause to suspect that the vulnerable person has been subjected to a reportable incident.

At issue is whether the Subject had reasonable cause to suspect that a reportable incident had occurred. The Subject's defense that she did not know that the Assistant Manager punched the Service Recipient but instead thought the Assistant Manager was joking or under the influence of pain relieving medication when she admitted she punched the Service Recipient, is not credible, as stated above. After hearing from Staff Person B that the Assistant Manager punched the Service Recipient in the head, at that point, the Subject had reasonable cause to believe that abuse or neglect had occurred. The record establishes that the Subject had received sufficient training concerning the reporting requirements to the Justice Center. Yet, the Subject did not make a report to the VPCR. Additionally, after the Assistant Manager admitted to the Subject in March that she punched the Service Recipient, the Subject still did not make a report to the VPCR. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5, 23, 25 and

26)

The record reflects that, in addition to her failure to report the incident to the VPCR, the Subject did not properly document the incident. The Subject did not follow [redacted] reporting procedures which required employees to report any incident involving abuse of service recipients to their immediate supervisor. Additionally, the Subject did not follow procedures under Part 624 of the NYCRR, including entering information into the T-Log for the Therap system that was inconsistent with Staff Person A's statements; not completing a GER or an ABC Behavioral Observation Form; and not notifying a nurse of a possible injury to, or requesting a medical professional examination of, the Service Recipient, after receiving information that the Service Recipient may have been injured. (Hearing testimony of Justice Center Investigator II [redacted] and Justice Center Exhibits 5, 7, 10, 16, 17, 24, 26, 27 and 28)

Consequently, the Justice Center has sufficiently established that the Subject committed abuse (obstruction of reports of reportable incidents) when she failed to report and properly document an allegation of physical abuse against 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 neglect and abuse alleged. 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 and abuse set forth in the substantiated report**.** Based upon the totality of the circumstances, the testimony presented, and the statements of witnesses, it is determined that the substantiated report is properly categorized as a Category 3 act(s).

DECISION: The request of [redacted] that Allegation 1 of 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 neglect.

Allegation 1 of the substantiated report is properly categorized, as a Category 3 act.

The request of [redacted] that Allegation 2 of 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 (obstruction of reports of reportable incidents).

Allegation 2 of the substantiated report is properly categorized, as a Category 3 act.

This decision is recommended by Elizabeth M. Devane, Administrative Hearings Unit.

DATED: September 15, 2016
Schenectady, New York

Elizabeth M. Devane
Administrative Law Judge