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

ADJUDICATION 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]

By: Steven M. Klein, Esq.
Senior Associate Counsel
CSEA
143 Washington Ave.
Albany, NY 12210

[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 [redacted] 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 properly determined that the Subject's neglect of the service recipient constituted category two conduct.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register. Category two conduct 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 not elevated to a category one finding shall 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: Schenectady, New York
January 20, 2015

David Molik
Administrative Hearings Unit

[redacted]

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

In the Matter of the Appeal of [redacted] Pursuant to § 494 of the Social Services Law	**RECOMMENDED DECISION AFTER HEARING** **ADJUDICATION CASE** [redacted]

Before: Sharon Golish Blum
Administrative Law Judge

Held at: Justice Center for the Protection of People with Special Needs
401 State Street,
Schenectady, New York 12305
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]
By: Steven M. Klein, Esq.
Senior Associate Counsel
CSEA
143 Washington Ave.
Albany, NY 12210

[redacted]

JURISDICTION

The New York State Vulnerable Persons' Central Register (hereinafter "the VPCR") maintains a report substantiating [redacted] (hereinafter "the Subject") for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a Subject of a 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.

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 [redacted] of neglect by the Subject of Service Recipient, [redacted]

2. The initial report alleges, in pertinent part, that on or about [redacted] to [redacted], the subject, [redacted] committed an act of neglect at the [redacted], located at [redacted] (hereinafter "the [redacted]") by failing to provide medical care when she did not notify the Nurse Administrator On Duty, (hereinafter the "NAOD"), that the vital signs of Service Recipient, [redacted], were outside of the specified parameters. (Justice Center Exhibit 4)

3. The initial report was made to the Justice Center for the Protection of People with Special Needs (hereinafter "the Justice Center") on [redacted], and was investigated by the Treatment Team Leader at [redacted].

4. On or about [redacted], the Justice Center substantiated the report against the Subject for *neglect*. The Justice Center concluded that:

Offense 1

From [redacted] to [redacted], at the [redacted], located at [redacted], while acting as custodian (DSA), you committed

[redacted]

> neglect when you failed to provide adequate medical care to a service recipient, in violation of protocols, which resulted in or was likely to result in physical injury or serious or protracted impairment of her physical, mental or emotional condition.
>
> This offense has been SUBSTANTIATED as a Category 2 offense pursuant to Social Services Law § 493.

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

6. At the time of the alleged neglect the Subject had been employed, for approximately four years, as a Direct Support Assistant (hereinafter "DSA") by the [redacted], which is operated by the [redacted]. The [redacted] is a facility or provider agency that is subject to the jurisdiction of the Justice Center. At the time of the alleged neglect, the service recipient, [redacted], who was 92 years old then, was a resident at the [redacted]. (Justice Center Exhibit 4)

7. The service recipient, [redacted], had been a long term resident at the [redacted] and was there at the time that [redacted] commenced her employment at the [redacted]. [redacted] was mildly developmentally disabled and suffered from numerous health issues, including hypothyroidism, edema, osteoporosis, hypertension and chronic cellulitis in both legs. (Justice Center Exhibit 24)

8. All of the [redacted] DSAs are trained that, unless otherwise noted, staff must notify a nurse immediately of any vital sign abnormalities that are outside of the clearly delineated parameters. This "vital signs rule" is extremely important as the DSAs have no medical training and are only in a position to take vital signs but not to interpret them. Reminders of the requirement to report abnormal vital signs are repeated in several documents as follows:

> a. It is clearly written by way of *Instructions to Staff* at the top of the document on which staff record the vital signs called the *Vital Sign Record*. (Justice Center Exhibit 6);
>
> b. It is set out in a document called *Emergency Guidelines* which was posted on the wall of the [redacted] medical room. (Justice Center Exhibit 38);
>
> c. It is set out in a training document called *Reminders for*

[redacted]

Documentation dated [redacted] acknowledged with her signature by [redacted]. (Justice Center Exhibit 8);

d. It is set out in a training document called *Audit at* [redacted] dated [redacted] acknowledged with her signature by [redacted]. (Justice Center Exhibit 10);

e. It is set out in a training document called *Weights/Vital Signs Parameters* [redacted] acknowledged with her signature by [redacted]. (Justice Center Exhibit 11); and

f. It is set out in a training document called *Training For When to Call the RN, Covering RN and NAOD*[redacted]. (Justice Center Exhibit 21)

9. At the end of [redacted], [redacted] doctor had altered her medications due to symptoms that she had been experiencing. Thereafter, on or about [redacted], [redacted] staff RN [redacted] became concerned with changes in [redacted] condition and gave instructions that staff monitor [redacted] vital signs once a shift, when [redacted] was awake. (Justice Center Exhibit 15)

10. On [redacted], at approximately 8:20 p.m., DSA [redacted], who was on duty at the [redacted] for the shift from 4:00 p.m. until 12:00 a.m., telephoned Nurse Administrator On Duty, (hereinafter "NAOD") RN [redacted] to report that some of [redacted] vital signs were not within the specified parameters. (Justice Center Exhibit 14)

11. RN [redacted] instructions to DSA [redacted] were to get [redacted] warmer with blankets and hot drinks and to take her temperature every hour until it reached 97 degrees. (Justice Center Exhibit 14)

12. Subsequent to speaking with RN [redacted], DSA [redacted] telephoned staff DA2 [redacted] at her home, to discuss [redacted] condition. DA2 [redacted] advised DSA [redacted] to take [redacted] vital signs every four hours and to contact the NAOD if her condition deteriorated. (Justice Center Exhibit 16)

13. At approximately 10:30 p.m., when [redacted] woke up to use the bathroom, blood had soaked through her pant leg due to a skin tear caused by extreme swelling. The wound was

bandaged by DSA [redacted] and she rechecked [redacted] vital signs, some of which were still outside of the specified parameters that, according to the "vital signs rule," required DSA [redacted] to contact the NAOD, which she did not do. (Justice Center Exhibit 5)

14. When the shift changed at 12:00 a.m., outgoing DSA [redacted] updated incoming DSA [redacted], the Subject, regarding [redacted] condition and the conversations that she had had with RN [redacted] and DA2 [redacted]. (Testimony of [redacted], Subject)

15. Later, during the night, DSA [redacted] helped [redacted] move from her bed to a reclining chair in the [redacted] living room. This was done so that her legs would be more elevated to combat the swelling, to allow her to rest more comfortably, as she was having difficulty breathing, and to allow DSA [redacted] the ability to keep a "good eye on her." (Testimony of [redacted], Subject)

16. DSA [redacted] checked [redacted] vital signs at 2:00 a.m. and 6:30 a.m. Some of [redacted] vital signs were still outside of the specified parameters that, according to the "vital signs rule," required DSA [redacted] to contact the NAOD. [redacted] temperature was too low, and both her systolic blood pressure and her respiration readings were too high. DSA [redacted] recorded the vital signs on the chart that has the "vital signs rule" clearly written as "*Instructions to Staff*" at the top of each page, but she did not notify the NAOD, as was required by the Instructions.

17. When DA2 [redacted] reported for work at the [redacted] on [redacted], at 7:30 a.m., she immediately arranged for [redacted] to be taken to [redacted] Hospital Emergency Department and she notified the NAOD, RN [redacted], of the situation.

18. On [redacted], at approximately 7:30 a.m., DSA [redacted] recorded in the *Nurse's Notes* that:

> "[redacted] was very restless overnight. Hard time seeing (even with her glasses) R. leg bandaged in AM. Both legs swollen edema. She did eat 1 egg, ½ c. fruit, 8oz.

[redacted]

H20, 4oz juice, 8 grapes. She is voiding x3. She is walking with assistance, but needs prompting. She is very weak. Vitals are very unstable. [redacted] notified 7:55@. [redacted] taken to ER for evaluation. House Mgr. made C.O.C. calls and notified Program site".

19. Upon examination at the hospital, [redacted] was admitted to the ICU with pneumonia and possible congestive heart failure. She passed away there six days later on [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 abuse or neglect.
- Pursuant to Social Services Law § 493(4), the category level of abuse that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse 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 or neglect presently under review was substantiated. A "substantiated report" means a report made "… if an investigation determines that a preponderance of evidence of the alleged neglect and/or abuse exists."

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 or neglect; and pursuant to Social Services Law § 493(4), the category level of abuse or neglect that such act or acts constitute.

[redacted]

The abuse and 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

[redacted]

> (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 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 neglect set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse 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;

[redacted]

(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, 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 cited in the substantiated report constitutes the Category of abuse set forth in the substantiated report.

[redacted]

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

DISCUSSION

The Justice Center has succeeded in establishing by a preponderance of evidence that the Subject, [redacted], did commit the neglect as alleged in the substantiated report.

The issue in this case is whether [redacted] conduct constituted neglect under SSL § 488(1)(h), when she failed to provide medical care by not following the clear protocol that required her to notify the nurse administrator on duty that the vital signs of [redacted] were outside of the specified parameters.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the course of its investigation. (Justice Center Exhibits 1-38) The investigation of the substantiated report was conducted primarily by [redacted] Treatment Team Leader [redacted], and was followed up by OPWDD Investigator [redacted]. They were the only witnesses that testified for the Justice Center at the hearing. Signed statements were obtained from RN [redacted], RN [redacted] and DA2 [redacted].

[redacted] testified on her own behalf and introduced one exhibit into evidence. (Subject Exhibit 1)

The strength of Justice Center's case against DSA [redacted] is in the undisputed fact that a clear and unambiguous duty existed for DSA [redacted] to have contacted the NAOD when [redacted] vital signs were abnormal. DSA [redacted] did not do so.

DSA [redacted] took [redacted] vital signs two times on [redacted], and on both occasions she was required to notify the NAOD, an unequivocal duty that she did not fulfill.

On [redacted], [redacted] recorded an interview with DSA [redacted] and questioned her as to why she did not telephone the NAOD regarding [redacted] abnormal vital

[redacted]

signs. DSA [redacted] was unable to provide an explanation. She indicated that she had tried to keep [redacted] comfortable, had taken steps to elevate [redacted] swollen legs and was focused on [redacted] temperature. (Justice Center Exhibit 37)

In her direct examination testimony, DSA [redacted] acknowledged that the *Instructions to Staff* on the *Vital Sign Record* were very clear, that she knew that she had no discretion to deviate from them, and that she had made a "terrible mistake" by not notifying the NAOD of [redacted] vital signs on [redacted]. She further stated that she "learned her lesson" and that she would make, "no judgment calls from now on."

In the final analysis the evidence shows that DSA [redacted] conduct did constitute neglect under SSL § 488(1)(h) as it was "...inaction or lack of attention that breaches a custodian's duty ... 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...." Included under that definition is subsection (ii) which further defines neglect as "... the 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...."

DSA [redacted] failed to notify the NAOD that [redacted] vital signs were outside the delineated parameters the two times that she checked them, a duty that she had no reason or justification to have ignored. The language of SSL § 488(1)(h) is very specific and clearly contemplates the type of situation as has arisen in this case.

The Justice Center has met its burden of proving by a preponderance of the evidence that DSA [redacted] committed the neglect alleged in the substantiated report. The substantiated report will not be amended.

The substantiation of the report having been determined, the next question to be decided

[redacted]

is whether the substantiated allegation constitutes the Category of neglect as set forth in the report. Pursuant to Social Services Law § 493(4), the substantiated allegation does fit within the meaning of a Category two neglect, to wit: conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. It is abundantly clear that DSA [redacted] failure to report [redacted] abnormal vital signs to a nurse caused a delay in the medical treatment of [redacted], who was admitted to the ICU upon examination, and that failure constituted a "serious endangerment to the health of the service recipient." The email from [redacted] MD [redacted] (Subject Exhibit 1), stating that he did not "believe the delay contributed to her death 6 days later" is not persuasive. There was no evidence that he had, at any point, examined [redacted], and the basis upon which he provided his cursory opinion is unclear.

A substantiated Category two finding of abuse or neglect will not result in the Subject being placed on the VPCR Staff Exclusion List. Reports that result in a Category two finding that have not been elevated to a Category one finding shall be sealed after five years.

DECISION: The request of [redacted] that the substantiated report [redacted] 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 properly determined that the Subject's neglect of the service recipient constituted category two conduct.

[redacted]

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

DATED: November 20, 2014
Spring Valley, New York