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

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

Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Thomas Parisi, Esq.

[redacted]
By: Margaret J. Fowler, Esq.
Levene Gouldin & Thompson, LLP
PO Box F-1706
Binghamton, New York 13902-0106

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

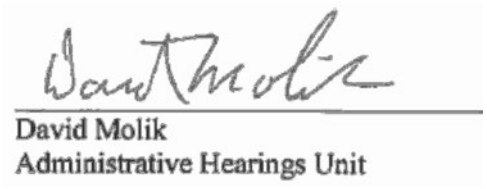
The substantiated report is properly categorized as a Category 3 act.

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

[redacted]

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: July 6, 2015
Schenectady, New York



David Molik
Administrative Hearings Unit

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

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

Before: Jean T. Carney
Administrative Law Judge

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

Parties: Vulnerable Persons' Central Register
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived.

Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Thomas C. Parisi, Esq.

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By: Margaret J. Fowler, Esq.
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Binghamton, New York 13902-0106

JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for abuse and/or neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a report substantiated on [redacted], dated and received on [redacted] of abuse and/or 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 or about [redacted], at [redacted], located at [redacted], while acting as a custodian, you committed neglect when, while responsible for watching a service recipient in the medical unit on suicide watch, you failed to immediately intervene when he obtained a piece of tile from the wall and cut his wrist with the tile.
>
> This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493.

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

4. The facility, located at [redacted], is a residential facility operated by the Office of Children and Family Services [hereinafter OCFS] Division of

Juvenile Justice and Opportunities for Youth, which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

5. At the time of the alleged abuse and/or neglect, the Subject had been employed by OCFS since [redacted] and the Subject worked as an YDA-3 (Subject Exhibit 1).

6. At the time of the alleged abuse and/or neglect, the Service Recipient was 14 years old, and had been a resident of the facility since [redacted], having been re-admitted after a previous release. The Service Recipient is an adjudicated youth with a history of trauma (Justice Center Exhibit 7).

7. In the days leading up to the incident, the Service Recipient was placed on suicide watch, having made several threats, attempts, and/or suicidal gestures (Justice Center Exhibit 17). In fact, on [redacted] a call was made to the VPCR regarding an attempt by the Service Recipient to cut himself with a piece of broken tile. That report was then linked to this report in the VPCR which accounts for the discrepancy in the date in the Substantiated Report.

8. A suicide watch requires that the resident have a dedicated staff member observing him at all times from a distance no greater than 3 feet from the end of his bed; and noting his demeanor every 15 minutes in a log (Justice Center Exhibits 6, and 11; Hearing testimony of Investigator [redacted] and Assistant Director (AD) [redacted]).

9. On [redacted], at approximately 7:55 a.m., the Subject was assigned to the suicide watch of the Service Recipient after the previously assigned staff person was relieved due to the Service Recipient spitting at her and threatening to throw urine at her (Justice Center Exhibit 17).

10. The surveillance video shows that shortly after 8:13 a.m. the Service Recipient kicks the wall of his room, bends over and picks something up off the floor where he had been

kicking. He then sits on the bed and makes cutting motions across his left wrist with something in his right hand (Justice Center Exhibit 24).

11. Surveillance video of a different camera angle shows the Subject during the same period of time looking into the Service Recipient's room, tilting her head, placing her hand on her radio but not removing the radio from her belt. She then motions to someone off camera, mimicking the same cutting motions that the Service Recipient had made (Justice Center Exhibit 24).

12. Nearly a full minute after the Service Recipient had begun making the cutting motions, AD [redacted] intervenes and places the Service Recipient into a protective hold, takes the piece of either tile or grout away from him and calls a code (Justice Center Exhibit 24, and Hearing testimony of AD [redacted]).

13. The Service Recipient was seen by a nurse who observed superficial cuts and some blood. The Service Recipient refused any medical care or treatment (Justice Center Exhibits 4, 23, and Hearing testimony of AD [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 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))

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute abuse and/or neglect; and pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488:

> 1 "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
>
> (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.
>
> (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual

contact with another service recipient who is a consenting adult who has consented to such contact.

(c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.

(d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

(e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.

(f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress

the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.

(g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.

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

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

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:

(a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:

(i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;

(ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

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

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

(d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

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

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

DISCUSSION

The Justice Center has established by a preponderance of evidence that the Subject committed a prohibited act, described as Allegation 1 in the substantiated report. The act committed by the Subject constitutes neglect.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation (Justice Center Exhibits 1-25). The investigation underlying the substantiated report was conducted by Investigator [redacted], who

testified at the hearing on behalf of the Justice Center. In addition, [redacted], the Assistant Director of Programs at [redacted] [hereinafter [redacted]], testified on behalf of the Justice Center.

The Subject testified on her own behalf and provided one document (Subject Exhibit 1).

The Justice Center submitted a visual only video of the incident, which was extremely helpful and illuminating evidence with respect to the substantiated allegations (Justice Center Exhibit 24).

The Justice Center proved by a preponderance of the evidence that the Subject committed the neglect alleged in the substantiated report. Specifically, the evidence establishes that the Subject breached her duty to the Service Recipient by failing to act when she observed him kick something loose from the wall and then try to cut himself with the item that he had kicked loose. Social Services Law § 488(1)(h) in pertinent part defines neglect as, "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."

The Service Recipient was recently re-admitted to [redacted] and had been on suicide watch for several days prior to this incident. The record reflects that he engaged in self-injurious behavior while being transported to the [redacted] for re-admission; during the ensuing days he made several suicidal gestures, including wrapping a blanket around his head, and wrapping a sheet around his neck (Justice Center Exhibit 6). In fact, the evening before this incident, on [redacted], an incident occurred where the Service Recipient tried to cut himself with a piece of tile. That was called in to the Justice Center and deemed a Significant Incident; and that report was linked to this incident occurring on [redacted]. This incident was not assigned an

investigator until [redacted], after the video recordings were reviewed by the [redacted] Director, [redacted] (Justice Center Exhibit 17).

It is undisputed that the Subject is a custodian within the meaning of the statute. She was assigned "one to one" to the Service Recipient while he was on suicide watch. OCFS policy dictates that when staff is assigned to suicide watch they must remain within three feet from the end of the bed where the Service Recipient is resting, and noting his demeanor every 15 minutes in a log (Justice Center Exhibit 11, Hearing testimony of AD [redacted]).

The Subject was aware that the Service Recipient had previously attempted to cut himself with tile from the room in the medical unit where he was staying while on suicide watch. During her testimony, the Subject stated that when she was assigned to the Service Recipient on the morning of [redacted], she attempted to tell her supervisor that it was not safe for the Service Recipient to be in that room (Hearing testimony of Subject). Therefore, she knew or should have known that she needed to watch the Service Recipient carefully in order to keep him safe.

However, the surveillance video clearly shows the Subject standing approximately two to three feet outside the Service Recipient's room, in contravention of OCFS policy (Justice Center Exhibits 24 and 11). When she saw the Service Recipient kick loose either tile or grout she did not call a code, in violation of OCFS policy (Justice Center Exhibit 10), nor did she intervene to try to prevent him from kicking the tile or grout loose. Finally, she violated another OCFS policy by failing to intervene when she saw the Service Recipient try to cut himself with the object he kicked loose from the wall (Justice Center Exhibit 11). The Subject had been trained in all of the pertinent OCFS policies, and therefore should have been fully familiar with the requirements thereunder. Yet she failed to do anything until the Assistant Director came onto the

unit. Therefore, the Subject breached her duty to the Service Recipient.

The Subject's inaction led to the Service Recipient injuring himself. The uncontroverted testimony shows that the Service Recipient succeeded in cutting his wrist to the point of causing bleeding. More importantly, if he were allowed to continue unchecked, his wounds could have been more significant. But for the intervention of AD [redacted], it is likely that the Service Recipient would have caused serious injury to himself. Thus, the Justice Center made a prima facie case of neglect against the Subject.

In her defense, the Subject contends that the policies and procedures at [redacted] [hereinafter [redacted]] were different from those at [redacted] and she had just transferred to [redacted] from [redacted], due to its closure (Hearing testimony of Subject). However, the Crisis Prevention and Management Policy specifically states that, "[t]his policy will be implemented in phases at [redacted] facilities as staff members are trained, beginning at [redacted]." That policy was issued on [redacted] (Justice Center Exhibit 8). In addition, according to the Subject's training history, she attended a half-day refresher class in Crisis Prevention Management on [redacted], which was after her transfer to [redacted] and only one month prior to this incident (Justice Center Exhibit 12). Under the Crisis Prevention and Management policy, physical restraint is warranted "[w]here emergency physical intervention is necessary to protect the safety of any person" (Justice Center Exhibit 8). Clearly, a restraint in this case was warranted pursuant to that policy and the Subject should have acted accordingly.

As another defense, the Subject contends that she did act appropriately under the circumstances. During her interrogation, the Subject claimed that she called a code and that AD [redacted] intervention was a result of that code. However, when confronted with the

surveillance video at the hearing, the Subject testified that she "pulled her pin" rather than calling a code (Hearing testimony of Subject). According to the Crisis Response and Radio Communication policy issued on [redacted], staff should only pull their pin when they are "in imminent risk of death or significant physical harm and no other method of summoning assistance is available or the situation renders other forms of communication impractical." This policy was implemented at [redacted] and [redacted] at the same time (Justice Center Exhibit 10). If the Subject had pulled her pin, Control Center staff would have announced the alarm and a record would have been made in the log (Justice Center Exhibit 10). No such entry was made that day (Justice Center Exhibit 4). Even if staff failed to enter the code through some oversight, it may reasonably be inferred that due to the serious nature of a duress signal, or pin being pulled, staff would rapidly converge on the area where the signal originated. Instead, the surveillance video shows AD [redacted] and Y DA III [redacted] calmly walking into the frame with no sense of urgency. In addition, AD [redacted] testified at the hearing that he went into the medical unit in order to check on the Subject, not in response to either a code being called or a duress signal (Hearing testimony of AD [redacted], Justice Center Exhibit 13). The evidence simply does not support the Subject's testimony that she pulled her pin.

In her statement, the Subject states that the Service Recipient threatened to "violate" her if she came into his room and that is why she did not intervene. Her statement went on to say that then AD [redacted] and YDA III [redacted] came in, implying that her intervention was unnecessary (Justice Center Exhibit 15). She also claimed that she told her supervisor that she believed it was inappropriate for a female staff person to supervise a male resident one on one, particularly when that resident is clad only in his boxer shorts (Hearing

testimony of Subject). While not an ideal situation, for whatever reason she was assigned to watch this young man, and therefore she had an obligation to keep him safe. It was incumbent on her to use her training, and do her job.

Finally, the Subject defends her failure to intervene by alleging that the Service Recipient was not actually attempting to kill himself, but was merely trying to get attention (Hearing testimony of Subject). Regardless of whether it was a serious attempt, a gesture, or a threat, the Subject was under an obligation to act. OCFS Suicide Risk Reduction and Response Policy dictates that staff should immediately intervene, regardless of the severity of the act, gesture, or threat (Justice Center Exhibit 11). Further, the Subject attended numerous trainings on this policy over her seven years of employment with OCFS and should have known her responsibilities thereunder (Justice Center Exhibit 12).

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 and/or neglect 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 level of abuse or neglect set forth in the substantiated report**.** Given the totality of the circumstances, the evidence and testimony presented, this ALJ finds that the substantiated report is properly categorized as a Category 3 act.

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

The substantiated report is properly categorized as a Category 3 act.

This decision is recommended by Jean T. Carney, Administrative Hearings Unit.

DATED: June 18, 2015
Schenectady, New York