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: Juliane O'Brien, Esq.

[redacted]

By: Ellen Mitchell, Esq.
CSEA, Inc.
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224

[redacted]

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

ORDERED: The request of [redacted] that the substantiated report dated [redacted], be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be amended and sealed by the Vulnerable Persons' Central Register, pursuant to SSL § 493(3)(d).

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: August 30, 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: John T. Nasci
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People with Special Needs
333 East Washington Street, Room 115
Syracuse, New York 13202
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
Delmar, New York 12054-1310
By: Juliane O'Brien, Esq.

[redacted]
By: Ellen Mitchell
CSEA, Inc.
143 Washington Avenue
Capitol Station Box 7125
Albany, New York 12224

JURISDICTION

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

FINDINGS OF FACT

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

1. The VPCR contains a "substantiated" report dated [redacted], of neglect by the Subject of a Service Recipient.

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

Allegation 1

> It was alleged that on [redacted], at the [redacted] located at [redacted], while actions as a custodian, you committed neglect when you failed to provide adequate care to a service recipient by failing to assist staff to ensure that his medical treatment plan was followed, even though you were present at the residence for that purpose, which resulted in the service recipient remaining in his wheelchair for over six hours and failing to receive proper treatment for an ulcer on his coccyx.
>
> 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, the [redacted], located at [redacted] is a group home for male and female

adults with developmental disabilities and is operated by the New York State Office for People With Developmental Disabilities (the OPWDD), which is an agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of OPWDD Investigator [redacted])

5. At the time of the alleged neglect, the Subject had been employed by the OPWDD since [redacted] 1988. The Subject worked as a Developmental Assistant 3 (DA3), also known as a Program Manager. As a DA3, the Subject was responsible for four medical [redacted] in [redacted] The Subject's duties included: assuring training was in place for her subordinates; overseeing and supervising House Directors, Assistant Directors and Support Staff; maintaining proper staffing; participating in annual and semi-annual meetings concerning service recipients; handling staff controversies; and updating service recipient Individual Plans Of Protective Oversight (IPOPO). (Justice Center Exhibit 45 - audio recording of interrogation of the Subject, Hearing testimony of the Subject and Justice Center Exhibits 2 and 44)

6. The Subject's work station was located in downtown [redacted] and she did not maintain a field office in any of the [redacted] under her management. The Subject worked in her downtown office fifty to sixty percent of the time. The Subject visited the [redacted] weekly to perform financial audits, check and approve schedules, deal with staff controversies, and meet with the parents of service recipients. (Justice Center Exhibit 45 - audio recording of interrogation of the Subject and Hearing testimony of the Subject)

7. The Subject did not regularly perform direct care for service recipients or review the service recipients' medical charts. As a DA3, the Subject was not allowed to be medically certified and was not authorized to perform any medical functions on or for service recipients. The Subject did not have knowledge of the medical care and/or positioning routines of individual service recipients who resided in the [redacted] under the Subject's charge. (Justice Center Exhibit 45 - audio recording of interrogation of the Subject, Hearing testimony of the Subject and Justice

Center Exhibits 2 and 44)

8. At the time of the alleged neglect, the Service Recipient was a thirty-six year old male with a mental health diagnosis of profound mental retardation. The Service Recipient also had a tracheostomy for breathing and a gastrostomy tube for feeding, and had been on hospice care since [redacted]. The Service Recipient was completely dependent on facility staff for all activities of daily living. (Justice Center Exhibits 7, 25 and 27; Justice Center Exhibit 45 - audio recording of interrogation of the Subject; and Hearing testimony of the Subject)

9. The Service Recipient had a history of developing a pressure ulcer on his coccyx, from which he was suffering at the time of the alleged neglect. The Service Recipient's pressure ulcer was treated with a cleansing and the application of a Duoderm dressing. The [redacted] staff were encouraged to reposition the Service Recipient while he was in his wheelchair every thirty to forty-five minutes and they were required to reposition him a minimum of one time every two hours. Facility staff were allowed to reposition the Service Recipient while he remained in his wheelchair. Staff were instructed to use the wheel chair only minimally when the Service Recipient was suffering from skin integrity concerns like the pressure ulcer on his coccyx. (Justice Center Exhibits 7, 22, 25, 26, 27, 28, 29 and 37; and Hearing testimony of the Subject)

10. The [redacted] was a single story structure with a basement. The [redacted] housed six service recipients, including the Service Recipient, on the main floor of the structure. None of the service recipients residing at the [redacted] were ambulatory or verbal and all of them required around-the-clock nursing care. The [redacted] was staffed only with Licensed Practical Nurses (LPNs) who provided all direct care services to the service recipients. (Justice Center Exhibit 13 and Hearing testimony of the Subject)

11. Each [redacted] under the Subject's responsibility was assigned a House Director and each shift at each [redacted] was assigned a Senior LPN on duty. LPN 1 was the House Director for the

[redacted] and the Senior LPN for the evening shift. LPN 3 was the Senior LPN for the day shift at the [redacted] The Senior LPN's duties included: managing the work schedule; managing staffing; managing work orders for the house; training new staff; ensuring staff assignments were completed; and working closely with the house Registered Nurse (RN). (Justice Center Exhibit 13 and Hearing testimony of the Subject)

12. The [redacted] was customarily staffed with two LPNs for the night shift (11:00 p.m. to 7:00 a.m.) and three LPNS for the day shift (7:00 a.m. to 3:00 p.m.) The customary minimum staff-to-service recipient ratio at the [redacted] was one staff to every three service recipients. When, at times, there was only one staff present in the [redacted], staff were required to put all of the service recipients in their wheelchairs for ease of evacuation in case of fire. This scenario would happen when staff were required to transport service recipients to appointments away from the [redacted]. (Justice Center Exhibit 8; Justice Center Exhibit 45 - audio recording of interrogations of LPN 3 and the Subject; and Hearing testimony of the Subject)

13. The medication routine at the [redacted] involved one of the LPNs, who was assigned as "Staff A", taking responsibility for the [redacted] narcotic medication by physically receiving the keys to the medication box from the previous shift Staff A, counting the medication in the box with the previous shift Staff A and receiving an oral report of medication administered by the previous shift Staff A. The LPN who was assigned as Staff A was responsible for holding the medication box keys and administering all medication to service recipients. (Justice Center Exhibit 9; and Justice Center Exhibit 45 - audio recording of interrogations of LPN 1, LPN 3 and the Subject)

14. Work responsibilities at the [redacted] were assigned to individual staff who were designated as "Staff A," "Staff B" or "Staff C." Staff A responsibilities included administering medication and gastrostomy tube feedings, and providing treatments outlined in the

Medication Administration Record (MAR) for all the service recipients in the [redacted]. Staff A responsibilities also included the care of one service recipient. Staff B responsibilities included checking, changing, repositioning, showering and caring for the tracheostomy of the Service Recipient and two other service recipients. Staff C responsibilities included the same care as Staff B for the two remaining service recipients. (Justice Center Exhibit 9)

15. On [redacted], the Subject made plans to conduct a financial audit of the [redacted] on [redacted]. On [redacted] a [redacted] night shift staff telephoned the Subject to advise her that the [redacted] would be short one LPN the next morning due to an unanticipated outside medical appointment for one of the service recipients, which would require two staff for transportation. The Subject instructed the night shift staff to ask the night shift Senior LPN, LPN 1, to stay a couple hours after the completion of her shift to provide coverage until the Subject could arrive at the [redacted]. Thereafter, LPN 1 agreed to provide the coverage. (Hearing testimony of the Subject)

16. On [redacted], at approximately 5:30 a.m. the Subject received a telephone call during which she was informed that her presence was needed at another [redacted]. As a result, she arranged for LPN 5, from another [redacted], to relieve LPN 1 and work at the [redacted] until she (the Subject) could arrive. (Hearing testimony of the Subject)

17. On [redacted], at 7:00 a.m., LPN 3, LPN 2 and LPN 4 arrived at the [redacted] for the start of the day shift. During the day shift, LPN 2 was assigned as Staff A, LPN 3 was assigned as Staff B and LPN 4 was assigned as Staff C. LPN 1 remained at the [redacted] after the completion of the night shift, and at 7:00 a.m. she gave the shift report to the day shift LPNs. In her shift report, LPN 1 stated that the Service Recipient had a bowel movement at approximately 3:45 a.m., and in the process of cleaning him, she removed the Duoderm dressing on his coccyx. She further reported that she did not replace the Duoderm

dressing because she knew that it would be replaced by the day shift staff later in the morning when the Service Recipient was bathed. (Justice Center Exhibits 8 and 9; and Justice Center Exhibit 45 - audio recording of interrogations of LPN 2, LPN 1 and LPN 3)

18. After the shift report on [redacted] at approximately 7:00 a.m., LPN 1 transferred the medication keys and responsibility to LPN 2 for the day shift. After receiving the medication keys, LPN 2 proceeded to administer medication to the service recipients, completing the task at approximately 8:30 a.m. LPN 4 attended to the care of the service recipients she was assigned to. (Justice Center Exhibit 45 - audio recording of interrogations of LPN 1 and LPN 2)

19. After the medication keys and responsibility were transferred to LPN 2, LPN 3 asked LPN 1 to transport one of the Service Recipients to an appointment. After LPN 1 told LPN 3 that she did not think that would be a good idea because she had been up all night and was tired, LPN 3 reluctantly decided to transport the service recipient herself and asked LPN 1 to start the van, which she did. (Justice Center Exhibit 45 – audio recording of interrogations of LPN 1 and LPN 2)

20. After LPN 3 left the [redacted] at approximately 7:30 a.m., LPN 2 asked LPN 1 to get the Service Recipient out of bed and into his wheelchair, which she did. At approximately 8:20 a.m., LPN 2 transferred the medication keys to LPN 1 anticipating that LPN 3 would not return before she had to leave with another service recipient for an appointment outside the [redacted]. After transferring the medication keys to LPN 1 and, upon LPN 3's return to the [redacted], at approximately 8:30 a.m., LPN 2 left the [redacted] with LPN 4 and a service recipient for the appointment, leaving LPN 1 and LPN 3 as the remaining staff in the [redacted] (Justice Center Exhibit 45 – audio recording of interrogations of LPN 1 and LPN 2)

21. Thereafter, LPN 1 transferred the medication keys to LPN 3. During the ten minutes she had the keys, LPN 1 did not administer any medication or otherwise perform any duty

associated with the possession of the medication keys. (Justice Center Exhibit 45 – audio recording of interrogations of LPN 1 and LPN 2)

22. At approximately 9:15 a.m., LPN 5 arrived at the [redacted] to relieve LPN 1 and LPN 1 signed out and left the [redacted]. (Justice Center Exhibit 45 - audio recording of interrogations of LPN 1, LPN 2 and LPN 3; and Justice Center Exhibit 8)

23. At 10:00 a.m., LPN 3 lifted the Service Recipient's body, while he remained in his wheelchair, to take the pressure off his bottom and then put him back down. (Justice Center Exhibit 45 - audio recording of interrogation of LPN 3)

24. When the Subject arrived at the [redacted] at 10:30 a.m., LPN 5 and LPN 3 were present. LPN 5 then signed out and left the [redacted] leaving LPN 3 and the Subject as the sole staff at the [redacted]. The Subject asked LPN 3 if she needed any help, and LPN 3 replied that she did not. The Subject then went to the basement with LPN 3 in order for LPN 3 to open the [redacted] financial books for the Subject's audit. The Subject remained in the basement to conduct the audit and asked LPN 3 to call her if she needed help, and LPN 3 returned upstairs. Thereafter, the Subject came upstairs about every fifteen minutes to ask questions of LPN 3 concerning the audit. Each time the Subject came upstairs, she also asked LPN 3 if she needed her assistance. Each time LPN 3 responded to the Subject that she did not need her assistance (Justice Center Exhibit 11; Justice Center Exhibit 45 – audio recording of interrogations of LPN 3 and the Subject; and Hearing testimony of the Subject)

25. LPN 2 returned to the [redacted] at 12:03 p.m., left again at 12:45 p.m. to get a Service Recipient's bag which she left at the earlier appointment, and returned again to the [redacted] at 1:40 p.m. Between 1:40 p.m. and 2:07 p.m., LPN 2 attended to her assigned service recipients and did laundry. She left the [redacted] again at 2:07 p.m. to pick up LPN 4 and another service recipient and returned to the [redacted] at 2:58 p.m. Between 10:30

a.m. and 2:58 p.m., LPN 3 and the Subject were the only two staff present continuously at the [redacted] (Justice Center Exhibit 45 – audio recording of interrogations of LPN 2, LPN 3 and the Subject; and Hearing testimony of the Subject)

26. A Hospice Registered Nurse (Hospice RN) came to the [redacted] at about 12:30 p.m. for a weekly assessment of the Service Recipient, but she did not examine the pressure ulcer on his coccyx. Sometime between 2:00 p.m. and 3:00 p.m., a massage therapist arrived and worked on the Service Recipient. (Justice Center Exhibits 12 and 19; and Justice Center Exhibit 45 – audio recording of interrogations of LPN 2 and LPN 3)

27. At approximately 3:00 p.m., the next shift staff arrived at the [redacted] and the day shift staff performed an oral shift report. The Subject had completed her audit and was seated in the kitchen listening to the shift report. During the shift report, it was determined that the Service Recipient's medical treatments, including cleansing and dressing the Service Recipient's coccyx pressure ulcer, were not completed by any of the day staff that were present at the shift report. Thereafter, the Subject contacted LPN 1 by text messaging to determine if she had completed the Service Recipient's treatments, and LPN 1 responded by text messaging that she had not completed them. The Subject then contacted the house RN to inform the RN of the error and request guidance. The Subject left the [redacted] at 4:10 p.m. (Justice Center Exhibits 11 and 19; Justice Center Exhibit 45 – audio recording of interrogations of LPN 2 and the Subject; and Hearing testimony of the Subject)

28. On [redacted], the Service Recipient was in his wheelchair continuously from approximately 7:30 a.m. to 3:00 p.m. During that time period, the Service Recipient was repositioned every two hours. (Justice Center Exhibits 4 and 19; and Justice Center Exhibit 45 - audio recording of interrogation of LPN 3)

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 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) (h), to include:

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

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), 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.

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 neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged 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 neglect cited in the substantiated report constitutes the category of neglect as set forth in the substantiated report.

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

DISCUSSION

The Justice Center has not established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-19, 22-39, 41, 43, 44 and 46[1]) The Justice Center also presented an audio recording of the OPWDD Investigator's interrogations of LPN 2, LPN 1, LPN 3 and the Subject. (Justice Center Exhibit 45) The investigation underlying the substantiated report was conducted by [redacted] OPWDD Investigator, who was the

[1] Justice Center Exhibits 20, 21, 40 and 42 were not offered.

only witness who testified at the hearing on behalf of the Justice Center. The Subject testified in her own behalf and provided no other evidence.

The facts are generally not in dispute and the following conclusions can be reasonably drawn from the hearing record concerning the events of [redacted] as they relate to the Service Recipient: 1) the Service Recipient's pressure ulcer dressing was removed at 3:45 a.m. and not replaced until after 3:00 p.m.; 2) the Service Recipient did not receive his medical treatments, which were normally administered in the morning, until after 3:00 p.m.; 3) the Service Recipient was in his wheelchair from 7:30 a.m. until 3:00 p.m.; and 4) while the Service Recipient was in his wheelchair, he was repositioned every two hours.

The following conclusions can reasonably be drawn from the hearing record concerning the events of [redacted] as they relate to the [redacted] staff: 1) LPN 2 was assigned as Staff A and as such she was responsible for the administration of medications and gastrostomy tube feedings, and the administration of treatments in accordance with the MAR for the Service Recipient, and she failed to carry out this responsibility; 2) LPN 3 was assigned as Staff B and as such she was responsible for checking, changing and repositioning the Service Recipient, which she did; 3) LPN 3 was the Senior LPN on duty and as such was responsible for, among other duties, assuring that staff assignments were performed and completed, which she failed to do in relation to LPN 2's assignments concerning the Service Recipient; 4) the Subject was present at the [redacted] from 10:30 a.m. until 4:10 p.m. for the dual purpose of conducting an audit and for maintaining minimum staffing while regular staff were transporting service recipients to appointments outside the facility; and 5) from 10:30 a.m. to 12:03 p.m., 12:45 p.m. and 1:40 p.m. and 2:07 p.m. to 2:58 p.m., LPN 3 and the Subject were the only two staff present at the [redacted].

In order to prove neglect the Justice Center must establish that the Subject owed a

custodian's duty to the Service Recipient, that conduct by the Subject breached the Subject's custodian's duty and that the Subject's breach of duty resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL §488(1)(h))

At the outset, the Subject contends that she was not a custodian as defined in the statute. New York State law defines the term "custodian" as: "... a director, operator, employee or volunteer of a facility or provider agency ..." (SSL §488(2)) Because the Subject was an employee of the OPWDD, which is an agency that is subject to the jurisdiction of the Justice Center, the Subject was a custodian as the term is defined by statute.

However, the Justice Center did not establish that the Subject breached a custodian's duty which she owed to the Service Recipient. The Justice Center contends that the Subject was present in the [redacted] to fill the position of a direct care worker in order to meet the minimum staffing requirements and, as such, she had a duty to ensure that the required care for the service recipients who were present in the [redacted] was performed, and that she breached her duty by failing to ensure that the Service Recipient's medical treatment and, specifically his pressure ulcer treatment, were performed.

The record reflects that LPN 2 was assigned the responsibility of administering medical treatment to the Service Recipient and that LPN 3 was assigned to change, check and reposition the Service Recipient. (Justice Center Exhibit 9) The record also reflects that the Subject was not medically certified and was not allowed to administer medication to the Service Recipient. (Justice Center Exhibit 13 and Hearing testimony of the Subject) The record further reflects that neither administering medical treatment for service recipients nor changing, checking and repositioning service recipients is included as a duty of DA3. (Justice Center Exhibit 44)

The Justice Center argues that the Subject had the duty to ensure that the Service

Recipient's medical treatment was performed. However, it is clear that oversight to the extent argued by the Justice Center was not included in the Subject's employment duties which were managerial and not hands-on in their nature. Instead, it was the Senior LPN's duty to ensure that specific tasks such as the medical treatments were performed. (Justice Center Exhibit 45 – audio recording of interrogations of LPN 1 and the Subject)

The Justice Center argues essentially that the Subject made herself a direct care worker by filling in as the second staff at the [redacted] in order to maintain minimum staff to service recipient ratios. However, the record is clear that the Subject was present at the [redacted] to perform an audit, which she did, and for the purpose of alleviating the necessity for the service recipients to be placed in their wheelchairs for ease of evacuation in case of fire, which was the required procedure when only one staff was present in the [redacted]. (Justice Center Exhibits 14, 23 and 45 – audio recording or interrogations of LPN 2 and Subject; and Hearing testimony of the Subject)

Even if the Subject had a duty to ensure that the tasks are performed, the record reflects that she was not familiar with the specific conditions and treatments of the individual service recipients, and specifically the Service Recipient. As a DA3, the Subject would not have such familiarity. (Hearing testimony of the Subject) Furthermore, the record reflects that each of the numerous times that the Subject asked LPN 3 if she needed her assistance, LPN 3 replied that no assistance was needed. Consequently, the Subject had no reason to check into whether or not the Service Recipient's treatments were completed or to suspect that the treatments were not completed.

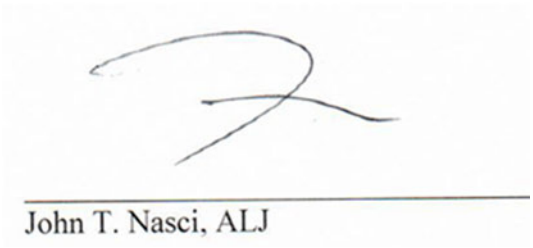
Because it is determined that the Subject had no duty to the Service Recipient under the circumstances of this case, it is not necessary to determine if there was a breach of duty or if the Service Recipient suffered actual harm or was likely to suffer harm as a result of a breach of duty.

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

DECISION: The request of [redacted] that the substantiated report dated [redacted], be amended and sealed is granted. The Subject has not been shown by a preponderance of the evidence to have committed neglect.

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

DATED: August 29, 2016
Schenectady, New York



John T. Nasci, ALJ