SUPERIOR COURT
OF THE
STATE OF DELAWARE

T. Henley Graves
Resident Judge

SUSSEX COUNTY COURTHOUSE
THE CIRCLE
P.O. BOX 746
GEORGETOWN, DE 19947
(302) 856-5257

July 22, 2003

William M. Chasanov, Esquire
Brown, Sheils, Beauregard & Chasanov
P.O. Box 742
10 East Pine Street
Georgetown, Delaware 19947

A. Ann Woolfolk, Esquire
Deputy Attorney General
Department of Justice
Carvel State Office Building
820 North French Street, 6th Floor
Wilmington, Delaware 19801

Date Submitted: July 17, 2003

RE: Deborah Lynch v. Carol Ellis, Director of the Division of Long Term Care Residents Protection
C.A. No. 02A-06-005

Dear Counsel,

This case comes before the Court on appeal from the Division of Long Term Care Residents Protection ("Division"). The Division issued a decision finding that Deborah Lynch ("Appellant") had committed "neglect," as defined in 16 *Del. C.* § 1131(3), and placing her on the Adult Abuse Registry ("Registry") for a period of three years. The Division's decision is affirmed for the reasons stated herein.

1. Factual Background and Procedural Posture

On October 17, 2001, the victim, Resident DE[1], suffered second and third degree burns from running bath water at Appellant's home. By letter dated November 29, 2001, the State sent notice to Appellant that it had placed her name on the Registry on November 13, 2001, with a finding of

[1] The victim's identity will be protected by the use of her initials only.

proposed concern of adult abuse. Appellant enlisted counsel and, pursuant to 11 *Del. C.* § 8564(b), requested an administrative hearing, which was held before a Hearing Officer of the Division on April 22, 2002. The Hearing Officer concluded Appellant had committed neglect as defined by statute and ordered her name to remain on the Registry for three years. Appellant appeals that decision to this Court as allowed by 11 *Del. C.* § 8564(b).

At the hearing below, the State presented evidence by way of live testimony and exhibits. As witnesses, the State called Appellant, Shirley Townsend, a registered nurse employed by the Division of Developmental Disabilities Services ("DDDS"), Theresa Mumford, a nurse consultant for DDDS, and Mary Anderson, Quality Assurance Administrator for DDDS. Appellant presented exhibits and the live testimony of Lorraine Blake, a DDDS client who also resided in foster care with Appellant in October of 2001. The evidence presented below established the following facts.

Appellant had served as an adult foster care provider for eighteen years for clients of DDDS prior to this incident. Resident DE, a sixty-year-old woman at the time, suffers from mental retardation and Parkinson's disease. Resident DE needs assistance with the activities of daily living including dressing and bathing. Appellant testified that Resident DE does not know how to adjust water temperature and is unable to turn a water spigot on or off by herself.

On October 17, 2001, Appellant had been running the water for Resident DE's evening bath when the telephone rang. At the time, Resident DE was sitting on the toilet and was partially undressed in anticipation of her bath. Appellant left the room to answer the telephone but testified that she was only out of the room for approximately one minute. When Appellant returned, she saw Resident DE, completely undressed, standing in the tub with steam rising from the water coming from the spigot. Appellant soaked a towel in cold water and wrapped it around Resident DE's feet. Appellant observed that Resident DE's feet were red on the top and the skin was loosened. She testified that Resident DE did not express pain or discomfort in response to Appellant's questioning.

Appellant proceeded to bathe Resident DE and prepare her for bed. Appellant testified that she attempted to call the State's "on-call" number but that she was unable to get through.

The following day, October 18, 2001, Appellant checked Resident DE's feet and they appeared dry. Again she asked Resident DE whether her feet hurt and received a negative response. Resident DE went to her scheduled day program and returned in the late afternoon. Upon Resident DE's return, Appellant noticed that the burns were oozing. Appellant testified that she tried to call the State's on-call line twice on October 18 but received a busy signal each time. Appellant did not try to contact Resident DE's physician because Resident DE had a scheduled appointment for the following afternoon.

Appellant went to the local pharmacy and requested assistance from the pharmacist. Resident DE did not accompany her to the store. The pharmacist recommended Neosporin Plus cream, an over-the-counter medication, and non-stick gauze pads. Appellant testified that although Resident DE denied that the burns hurt her, Appellant knew that they were causing her pain based on their appearance. Appellant applied Neosporin Plus to the burns but did not give Resident DE any oral pain medication. Appellant also said that she did not consider the burns serious enough to warrant a visit to the emergency room.

Shirley Townsend, a registered nurse, also teaches a class in "Assistance with Medications," which foster care providers are required to take annually. Ms. Townsend testified that she teaches foster care providers that over-the-counter medications may not be given to the client without a standing medical order. This directive stands, regardless of whether the medication is administered orally or topically.

Theresa Mumford, a nurse consultant with DDDS, testified that she received a call from Appellant on October 19, 2001, at noon. After Appellant described Resident DE's injuries to Ms. Mumford, Ms. Mumford told Appellant that Resident DE needed to be taken to a physician immediately.

Mary Anderson, a Quality Assurance Administrator for DDDS, conducted the investigation in this case and was present at the doctor's office on October 19, 2001, when Resident DE's burns were examined and treated. While Ms. Anderson was on the witness stand, the State introduced a copy of the foster care contract between DDDS and Appellant. The State emphasized two requirements of this contract: (1) that the care provider "seek immediate medical attention for emergencies of any individual residing in the home and [] notify DDDS as soon as possible, using the 24 hour on-call system, if necessary," and (2) that the care provider "[n]otify DDDS immediately, of any serious illness, injury, hospitalization, accident, AWOL, or death of the individual residing in foster care, using the 24 hour on-call system, if necessary."

Ms. Anderson explained the DDDS policy and procedure on "Bath/Shower Water Temperature Monitoring." The policy requires that the care provider monitor the water temperature before any bath or shower "unless the individual can independently adjust his/her own water temperature." Ms. Anderson testified that the focus of her investigation was whether Resident DE was left unsupervised at the time of her bath and whether Appellant sought appropriate medical care for Resident DE's injuries in a timely fashion.

Lorraine Blake testified on behalf of Appellant. Ms. Blake was living at the Appellant's house at the time of this incident. Ms. Blake testified that the incident happened during the day and that she, Appellant, and Resident DE went immediately to the doctor's office. She also testified that she witnessed Resident DE get into the bath tub and turn up the water temperature.

Following a review of the evidence, the Hearing Officer concluded that Appellant was guilty of "neglect" as defined in all three of the following categories:

a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.
b. Failure to report patient or resident health problems or changes in health condition to an immediate supervisor or nurse.
c. Failure to carry out a prescribed treatment plan for a patient or resident.

16 *Del. C.* § 1131(3).

The Hearing Officer made the following findings of fact and conclusions of law:

16 Del. C. § 1131(3)(a)
First of all, [Appellant] herself testified that her foster care client, a 60 year-old woman with mental retardation and Parkinson's disease, was not capable of taking her own bath. She said that Resident DE did not comprehend how to adjust the water temperature or how to turn the water off by herself.

And, yet, after [Appellant] started running the bath water, she left Resident DE unattended in the bathroom while she went to answer the phone . . . . Especially with the risk factor of running water in the tub, and considering Resident DE's capabilities, [Appellant] should not have left her unsupervised at bath time, even for a short time. To do so was a lack of attention to the safety needs of this resident in connection with bathing.

16 Del. C. § 1131(3)(b)
Secondly, [Appellant] used poor judgment in her failure to seek medical attention in a timely manner for Resident DE's burns. [Appellant] herself testified that right after the bathtub incident on the evening of October 17, Resident DE's feet were red on the top and the skin was loosened. . . . An adult foster care provider, especially one with 18 years experience, should know to call the doctor of the doctor's on-call service immediately, as well as to call the state agency that contracted with her for Resident DE's care, as required by DDDS contract. But, she did not call the doctor that night, and she said she placed one call to the DDDS on-call line on October 17, but it was busy.

In fact, [Appellant] did not call the doctor's office until the morning of October 19, at least 36 hours after Resident DE suffered the burns. And, she had more warning signs of the need for medical treatment in the interim. For example, on the afternoon of October 18, when Resident DE returned from her day program, [Appellant] saw that her client's burns were oozing with the moisture leaking through her socks. And, despite Resident DE's repeated responses that she was not in pain, [Appellant] herself said she knew better, that it had to hurt if it was oozing like that. Yet, she still did not call the doctor, and she did not vigorously try to reach DDDS. . . . Instead, she talked to a pharmacist who suggested an over the counter cream and gauze dressing. The pharmacist did not actually see the burns on Resident DE's feet, but relied on [Appellant's] description of those burns.

[Appellant] waited until Resident DE had a regularly scheduled medical appointment on October 19 to have her burns examined and treated by a nurse or doctor. [Appellant] said she did not even consider calling the medical practice to see if it had on-call availability to deal with Resident DE's burns. And, it was not until just an hour and a half before the October 19 doctor's appointment that [Appellant] called Theresa Mumford, her DDDS nurse, at Noon to report Resident DE's burns.

. . .

> [W]hile as a layperson, [Appellant] would not be expected to know the specific degree of burns suffered by her client, the photographs of the burns on Resident DE's feet taken on October 19 do not look like merely a bad sunburn [as Appellant suggested while testifying] or even like "minor" burns. . . . And, even if the skin may have appeared worse with the intervening two days since the scalding, the graphic photos depict such severe burns that it is unimaginable that their appearance earlier would not have brought the common sense realization that immediate medical evaluation was needed.
>
> Thus, from the time Resident DE suffered the burns on the evening of October 17, 2001, [Appellant] failed to report her client's significant health problem to a doctor or to the DDDS agency for at least 36 hours. This amounts to a second ground for neglect . . . .
>
> **16 Del. C. § 1131(3)(c):**
>
> Thirdly, [Appellant] failed to follow the prescribed treatment plan for her client in connection with her standing medical orders ("SMO"). While Resident DE's SMO indicated *not* to use Neosporin for "minor cuts", [Appellant] testified that she thought she was following the SMO when she used Neosporin Plus. In a sense, however, that is a secondary point because, as Ms. Mumford and other DDDS nurses testified, a SMO is really not intended to address major burns because those are emergencies that require immediate medical attention by a physician. The burns suffered by Resident DE in this case were certainly major burns, and as such, warranted timely and appropriate medical attention, as addressed in the second point above.

The Hearing Officer then concurred with the State's recommendation of three years as the length of time for which Appellant's name should remain on the Registry.

Appellant timely appealed to this Court.

2. Issues Presented for Review

Appellant presents three issues for consideration:

i. Was Appellant was denied due process of law because the statute subjecting Appellant to placement on the Registry is unconstitutionally vague?

ii. Were the findings of the Hearing Officer supported by substantial evidence and the conclusions of law supported by the findings of fact?

iii. Was the Hearing Officer's decision to place Appellant on the Registry for a three year period an abuse of discretion?

The Court will consider these arguments in turn.

3. Discussion

A. Standard of Review

A decision rendered by DHSS is appealable on the record. 11 *Del. C.* § 8564(b). In reviewing a DHSS decision, this Court must determine whether the Board's findings are supported by substantial evidence and whether its legal conclusions are free from error. *Unemployment Ins. Appeal Bd. v. Martin*, 431 A.2d 1265 (Del. 1981); *Ponchvatilla v. United States Postal Serv.*, Del. Super., C.A. No. 96A-06-19, Cooch, J. (June 9, 1997). In looking for "substantial evidence," the Court looks for "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Gorrell v. Division of Vocational Rehab.*, Del. Super., C.A. No. 96A-01-001, Graves, J. (July 31, 1996) (Letter Op.), at 4. Moreover, "[i]t is not the appellate court's role to weigh the evidence, determine credibility questions or make its own factual findings, but merely to decide if the evidence is legally adequate to support the agency's factual findings." *McManus v. Christiana Serv. Co.*, Del. Super., C.A. No. 96A-06-013, Silverman, J. (Jan 31, 1997) (Op. and Order), at 4. With respect to any discretionary decisions made by the agency, the Court must determine that they were not made either arbitrarily or capriciously. *Warmouth v. Delaware State Bd. of Examiners in Optometry*, 514 A.2d 1119, 1208 (Del. Super. 1985).

B. Merits of Argument

a. Constitutionality of 16 *Del. C.* § 1131(3)(a)

Appellant asserts she has been deprived of her livelihood as a result of the Division's decision and, thus, she is entitled to due process protections. Appellant complains that 16 *Del. C.* § 1131(3) violates these due process guarantees because it is unconstitutionally vague.

Effective July 2, 1999, the legislature adopted an amendment to the subchapter of the Delaware Code that addresses the abuse, neglect, or mistreatment of residents or patients in nursing facilities and other similarly licensed facilities. The word "intentional" was deleted from three of

the subsections of 16 *Del. C.* § 1131(3), which defines "neglect." The statute now reads, in pertinent part:

> Neglect shall mean:
>
> a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.
> b. Failure to report patient or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse.
> c. Failure to carry out a prescribed treatment plan for a patient or resident.

16 *Del. C.* § 1131(3). Specifically, Appellant argues that the statute is void for vagueness because, absent a *mens rea* requirement, an ordinary person cannot decipher permissible "lack of attention" from impermissible "lack of attention."[2] Assuming, *arguendo*, that Appellant has standing to challenge this claim,[3] the Court concludes this argument lacks merit.

In *Gold Liquor Co. v. Four Roses Distillers Co.*, the Delaware Supreme Court adopted federal law as it concerns a vagueness challenge to a civil statute:

> [A] statute which imposes a standard of conduct for the breach of which an individual will be held responsible must define the conduct with sufficient particularity to enable him to make his conduct conform. If men of common intelligence must, of necessity, guess at its meaning and reach different conclusions as to its meaning, the statute is unconstitutionally vague. While the question of vagueness has usually arisen in criminal cases, nevertheless in the context of the application of due process of law civil statutes as well are tested by it.
>
> If the language of a statute is attacked on the ground of vagueness, it will be upheld if the language used has a well-settled meaning in law, even though there could be difference of opinion as to elements of degree. Nor will a statute be held unconstitutional if the courts can look through imprecision of language to the intent of the legislature.

---

[2] Appellant limits her void-for-vagueness challenge to the definition of neglect set forth in 16 *Del. C.* § 1131(3)(a).

[3] The Division points out that Delaware law does not prohibit persons placed on the Registry from working with the population at issue, the law merely requires that certain employers check the Registry before hiring someone. This may be true, but the Court is comfortable assuming, for purposes of argument, that Appellant has effectively been prohibited from pursuing her livelihood.

281 A.2d 19, 22 (Del. 1971) (citations omitted).

Recently, the United States District Court for Delaware struck down a provision of the Delaware Code as unconstitutionally vague. The relevant statute prohibited the Delaware Department of Corrections from having "any personal contact" with an "offender." In striking down the provision, the Court noted, "[v]agueness concerns are particularly implicated where a law or regulation has no clarifying interpretation or settled usage and is so unclear that it requires a person to guess at its contours or misleads a person into believing he or she is compliant with it." *Via v. Taylor*, 224 F. Supp. 753, 766 (D. Del. 2002). The Court concluded that the statute was void for vagueness because "it is potentially open for discriminatory enforcement, fails to set forth clearly the conduct that is prohibited, appears to create a safe harbor for employees who report the allegedly infringing relationship, and fails to notify an individual of the disciplinary measures that could be taken for a violation of its prohibition." *Id*. Indeed, the initial responsibility for reporting a potentially inappropriate relationship lay with the individual officer. There were no written standards advising the employees how to exercise their discretion regarding offender contact.

On the other hand, the Delaware Supreme Court has upheld a statutory provision that permitted[4] courts to terminate parental rights upon a finding that a parent was "not fitted to continue to exercise parental rights." *In re Dingee*, 328 A.2d 139, 140 (Del. 1974). In that case, the appellant contended that the Legislature should have defined the phrase "not fitted." The Court held the contention without merit. In so doing, the Court opined:

> No inflexible rule can or should be laid down by which unfitness of a parent to have the custody of his child may be determined, but each case must be decided on its own peculiar facts. The words "not fitted" have a common and ordinary usage and accepted dictionary meaning and, as to matters pertaining to custody of children, are to be read generally as meaning "unfitted for parental duties."

[4] The statute has since been amended.

Id. The Supreme Court has reaffirmed these principles in the case of *In re Hanks*, 553 A.2d 1171 (Del. 1989), in which the words "plan" and "adequately," as used in a statute providing for the termination of parental rights, were challenged as impermissibly vague. In *In re Hanks*, the Court noted that the United States Supreme Court has emphasized that "lack of precision is not itself offensive to the requirement of due process." *Id*. at 1176 (quoting *Roth v. United States*, 354 U.S. 476, 491 (1957)). Indeed, the Court stated, "standards of mathematical precision are neither possible nor desirable in the field of family law." *In re Hanks*, 553 A.2d at 1176. After reaffirming the principle that family law cases should be evaluated on a case-by-case basis, the Court held that the words "plan" and "adequately" are "simple, nontechnical words." *Id*. The Court concluded that "[i]ndividuals to whom this statute applies need not guess as to their meaning." *Id*.

The Superior Court of New Castle County has upheld the constitutionality of a statute that delegated the power to terminate certified teachers for "immorality" to school boards. *Skripchuk v. Austin*, 379 A.2d 1142 (Del. Super. 1977). The Court's rationale emphasized the broader context of the legislation as well as procedural due process considerations:

> The state has a legitimate interest in enacting this kind of statute. Although there might be disagreement about the meaning of "immorality" in some cases, by the very nature of the term, which refers to the common mores of society, one would expect broad agreement in most cases. Moreover, the term will be construed in the context in which it appears in this chapter to refer to *such immorality as may reasonably be found to impair the teacher's effectiveness by reason of his unfitness or otherwise.* The statutory provisions for notice, hearing, and judicial review protect certified teachers from arbitrary termination or infringement of their constitutional rights.

Id. at 1143 (emphasis supplied).

A case out of Mississippi bears a remarkable resemblance to the one before the Court today. In *Molden v. Mississippi State Department of Health*, two nurse aides were removed from the Certified Nurse Aide Roster after they were found to have neglected a long-term resident at their place of employment. 730 So. 2d 29 (Miss. 1998). The nurse aides left the resident in a whirlpool bath for literally one minute while running out of the room to retrieve bathing supplies. Upon their

return, they failed to notify immediately their superiors of the incident. The nurse aides challenged the Department of Health regulation's definition of "neglect." The Court upheld the standard as adopted by the Department of Health and summarized:

> The Department's regulations define the term "neglect" as "the failure to supply the long term care resident with the care, food, clothing, shelter, health care, supervision or other services which are necessary to maintain his mental and physical health." Regulations § I(C)(12). We find that while the Department's definition of neglect is broad and general and does not provide any specific examples of what actions may constitute neglect, the definition does provide a sufficiently definite warning as to the proscribed conduct *when measured by common understanding and practices*. We further find that the definition of neglect adopted by the Department is clearly sufficient to give one warning that leaving a long term care resident unattended in a whirlpool bath with scalding water and then not reporting the change in the resident's condition to the nurse in charge would amount to neglect.

730 So. 2d at 40 (emphasis supplied).

The Court finds the case at bar to be more in keeping with the later cases cited above than with the federal district court case of *Via v. Taylor*. Like the statutes at issue in *In re Dingee*, *In re Hanks*, and *Skripchuk*, the provision before the Court must be read within the context of the surrounding code provisions and DDDS regulations. DDDS takes care to provide its foster parents with training as well as reference material, upon which the care givers are expected to base their care for the clients in their care. There is a standard procedure set in place to handle allegations of neglect, detailed at 16 *Del. C.* § 1134. The repercussions of a finding of neglect are set out in the Code, be they civil or criminal. 16 *Del. C.* § 1137; 11 *Del. C.* § 8564(b); 16 *Del. C.* § 1136. Appellant was entitled to, and did, challenge the finding of neglect. 11 *Del. C.* § 8564(b). She attended the administrative hearing, represented by counsel, and presented evidence to the Hearing Officer. Appellant is now exercising her right to judicial review of the Division's decision, as provided for in 11 *Del. C.* § 8564(b).

Clearly, the State has a legitimate interest in protecting the health and welfare of the clients it places in the foster care system. The words "lack of attention" have common, nontechnical meanings. In relevant context, the definitions for "neglect" contained in 16 *Del. C.* § 1131(3) may

be commonly understood as requiring one who provides care to a mentally and/or physically challenged client to be able to anticipate that client's caretaking needs. That is not to say the job is an easy one. However, as in the family law context, the Court observes that the unique nature of adult foster care relationships requires case-by-case factual analysis. This flexibility, however, does not render the statute unconstitutional for want of specificity.[5] The Court finds that the language of 16 *Del. C.* § 1131(3) is sufficiently definite such that it should have put Appellant on notice that her behavior failed to conform to its standards.[6] Appellant's void-for-vagueness argument fails to persuade the Court that the statutory definition of "neglect" is unconstitutional.

b. Substantial Evidence and Legal Error

Appellant argues that substantial evidence does not support the findings made by the Division. The Court disagrees. As is widely known, this Court's role when reviewing agency decisions is decidedly narrow. The decision to curtail the Court's review in matters on the record conforms to the age-old deference given to the credibility determinations of the fact finder. In this case, the parties do not disagree on the relevant facts. Appellant vacated the room while Resident DE awaited her bath. The bath water was running and it was warm. Resident DE was not capable of regulating or adjusting water temperature by herself. Appellant, having the near-continual opportunity to observe the burns over the course of the next thirty-six hours, did not take Resident DE to a physician or hospital for treatment but rather administered treatment herself.

---

[5] Appellant, somewhat confusingly, argues that 16 *Del. C.* § 1131(3) is unconstitutional because the language is too vague, absent a *mens rea* requirement. While it is true that varying degrees of conduct fall under the statute, the penalty is not predetermined. Thus, the consequences of an act, or failure to act, can be, and *are* when one requests a hearing, weighed by the Division. Appellant's references to *mens rea*, however, are misplaced. *Mens rea* is defined as, "The state of mind that the prosecution, to secure a conviction, must prove that a defendant had when committing a crime; criminal intent or recklessness." *Black's Law Dictionary* 999 (7th ed. 1999). *Mens rea* is not applicable.

[6] The neglect of which Appellant was charged was distinctly related to the activity of bathing. Section 1131(3) clearly sets out the activities of toileting, bathing, meals and safety as those requiring oversight.

Despite Appellant's undisputed contention that Resident DE had never moved into the bathtub by herself, the Hearing Officer could have reasoned that a simple, and responsible, decision to turn off the running water before leaving the room would have prevented the accident. Furthermore, the Hearing Officer could find that the failure to do so constituted neglect.

Likewise, the Hearing Officer was free to conclude that Appellant had failed to report a resident's health problem to an immediate supervisor or nurse, in violation of 16 *Del. C.* § 1131(3)(b). Appellant testified that, over a period of two days, she tried to call the State's on-call line a total of three times but was unable to get through to anyone. At most, these attempts resulted in an average of one call every twelve hours. The Hearing Officer concluded this effort was insufficient, especially after observing that testimony showed Appellant was not only aware of the on-call line, but had frequently availed herself of its service in the past. The Hearing Officer's decision to do so is supported by the record.

The Hearing Officer also held that Appellant was in violation of 16 *Del. C.* § 1131(3)(c) in failing to carry out a prescribed treatment plan for a resident. Ms. Townsend, a registered nurse employed by DDDS testified that no over-the-counter treatments may be administered to a resident without a standing medical order. Although Appellant may have believed she was following Resident DE's standing medical order when she applied Neosporin Plus, the standing medial order identified only instructions to follow if Resident's DE suffered a minor cut or abrasion. The Hearing Officer determined that Appellant should have been able to tell that the burns suffered by Resident DE were not minor. Appellant's own testimony supports that conclusion. The Hearing Officer's decision to consider this failure to follow DDDS procedure a violation of 16 *Del. C.* § 1131(3)(c) was supported by her factual findings.

c. Abuse of Discretion

Finally, Appellant argues that the Hearing Officer abused her discretion by placing Appellant on the Registry for a period of three years. Judge Silverman recently reiterated the standard with respect to the Court's review of a penalty imposed by an administrative agency:

> Choice of penalty is within an administrative agency's discretion if it is based on substantial evidence and not outside its statutory authority. To find abuse of discretion, the Court determines whether the agency's chosen penalty is so disproportionate to the offense in light of all the circumstances as to be shocking to one's sense of fairness. If the Court so finds, it shall reverse or modify the agency's decision and render an appropriate judgment.

P. Wilson Exterminating Co. v. State of Delaware Dep't. of Agric., Del. Super., C.A. No. 00A-08-012, Silverman, J. (June 27, 2001) (Order), at 3.

Appellant points to her incident-free background as well as other mitigating circumstances in support of her argument that the penalty imposed against her was disproportionally severe. Appellant notes that Resident DE did not express feelings of pain, the burns did not become infected and that the injuries did not require hospitalization. There is no indication that the Hearing Officer ignored these considerations. While three years is a substantial period of time, the intention of the Hearing Officer was to restore Appellant to her original unblemished status at the end of the three year period. The Hearing Officer did not place Appellant's name permanently upon the Registry. This decision, in itself, indicates that the Hearing Officer considered mitigating circumstances. The resultant three year placement on the Registry is not so egregious that it could be considered "shocking to one's sense of fairness."[7] The Court declines to find an abuse of discretion and the Hearing Officer's decision is affirmed in this regard, as well.

[7] Appellant did not provide any evidence to the Court that would indicate that a three year placement on the Registry is out of proportion to any penalties imposed under similar facts in the past.

4. Conclusion

A review of the record satisfies the Court that the Division's findings of fact and conclusions of law are supported by substantial evidence and are free from legal error. Considering the foregoing, the Division's decision to place Appellant on the Registry for a period of three years after a finding of neglect is affirmed.

IT IS SO ORDERED.

Very Truly Yours,

T. Henley Graves

oc: Prothonotary's Office
cc: DHSS: Division of Long Term Care Residents Protection