

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

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In the Matter of the Appeal of

████████████████████

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AFTER HEARING**

**ADJUDICATION CASE**

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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: Todd Sardella, Esq.

████████████████████  
████████████████████  
████████████████████

By: Andrew Alter, Esq.  
Legal Services of Hudson Valley  
101 Hurley Avenue, Suite 3  
Kingston, NY 12401

██████████

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 ██████████ that the substantiated report dated ██████████ ██████████, ██████████, dated ██████████ be amended and sealed is denied with respect to the allegation that that he dragged the Service Recipient by his hands, along the floor, the Subject has been shown by a preponderance of the evidence to have committed physical abuse.

The request of ██████████ that the substantiated report ██████████ ██████████ dated ██████████ be amended and sealed is granted with respect to the allegation that he committed neglect by shutting a Service Recipient in his bedroom and then holding the door shut.

The substantiated report is amended to be a Category 3 act.

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

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

**DATED:** Schenectady, New York  
March 17, 2015



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David Molik  
Administrative Hearings Unit

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

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In the Matter of the Appeal of

████████████████████

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**ADJUDICATION CASE**

████████████████████

Before: Sharon Golish Blum  
Administrative Law Judge

Held at: New York State Justice Center for the Protection  
of People with Special Needs  
11 Perlman Drive  
Spring Valley, New York 10977  
On: ████████████████████

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  
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161 Delaware Avenue  
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By: Todd Sardella, Esq.

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████████████████████

By: Andrew Alter, Esq.  
Legal Services of Hudson Valley  
101 Hurley Avenue, Suite 3  
Kingston, NY 12401

**JURISDICTION**

The New York State Vulnerable Persons' Central Register (hereinafter "the VPCR") maintains a report substantiating [REDACTED] ("the Subject") for abuse and 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.

**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 "substantiated" reports dated [REDACTED], [REDACTED] [REDACTED], dated [REDACTED] of abuse and neglect by the Subject against a Service Recipient.

2. The initial report alleges, in pertinent part, that on [REDACTED], the Subject committed acts of abuse and neglect at [REDACTED], ("the facility") by, firstly, dragging a Service Recipient by his arms from a common room into his bedroom and, secondly, by closing the bedroom door and holding it shut while the Service Recipient kicked and screamed inside the room. (Justice Center Exhibit 1)

3. On or about [REDACTED], the Justice Center substantiated the report against the Subject for abuse and neglect. The Justice Center concluded that:

**Offense 1**

It was alleged that on [REDACTED], at [REDACTED] [REDACTED], located at [REDACTED], while acting as a custodian Child Care Worker (CCW), you committed an act of physical abuse and/or neglect when you dragged a service recipient by his arms to his bedroom.

This offense has been SUBSTANTIATED as Category 2 offense pursuant to Social Services Law § 493.

**Offense 2**

It was alleged that on [REDACTED], at [REDACTED], located at [REDACTED], while acting as a custodian (CCW), you committed an act of neglect when you breached your duty towards a service recipient by shutting him in his bedroom and then holding the door shut so that he could not exit. This action was likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of the service recipient.

This offense has been SUBSTANTIATED as Category 3 offense pursuant to Social Services Law § 493.

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

5. The [REDACTED], located at [REDACTED], is a group home for challenged boys, ages 10 to 21 years old, and is licensed by the New York State Office of Children and Family Services (OCFS), which is a facility or provider agency that is subject to the jurisdiction of the Justice Center.

6. At the time of the alleged abuse and neglect, the Subject, [REDACTED], had been employed at the facility for approximately three years as a CCW. His regular shift was from 1:00 p.m. until 11:00 p.m. and he also worked, on some occasions, in the mornings, from 6:30 a.m. until 9:00 a.m. (Testimony of [REDACTED]; Subject)

7. At the time of the alleged abuse and neglect, the Service Recipient was 16 years of age and had been a resident of the facility for approximately 3.5 years. The Service Recipient is a young person with a diagnosis of Pervasive Developmental Disorder and ADHD. (Justice Center Exhibit 10)

8. At approximately 9:00 p.m. on [REDACTED], [REDACTED] and another CCW,

██████████, were supervising six residents who were watching TV in the common room of the cottage. Some confrontational words were exchanged between some of the residents, including the Service Recipient. (Justice Center Exhibit 30)

9. ██████████ approached the Service Recipient, who had been resting on the floor with a pillow and blanket. After some discussion, ██████████ pulled the pillow and blanket away from the Service Recipient and put them into the Service Recipient's bedroom. (Justice Center Exhibit 30)

10. ██████████ then returned to the Service Recipient, who had stood up and tried to grab another resident's pillow away from him. ██████████ redirected the Service Recipient away from the other boy. (Justice Center Exhibit 30)

11. As a result of that interaction, the Service Recipient wound up seated on the floor again. ██████████ spent a little over two minutes standing over and speaking to the Service Recipient, who had moved from seated to lying on his back. (Justice Center Exhibit 30)

12. ██████████ then took both of the Service Recipient's hands and dragged him a short distance along the floor and into the Service Recipient's bedroom, where he let go and exited the room, closing the door after himself. (Justice Center Exhibit 30)

13. For a little over 90 seconds, ██████████ remained by the door, presumably to prevent the Service Recipient from leaving the room. ██████████ opened the door, entered the bedroom, leaving the door open, and remained in the room for just under two minutes. He then reemerged and closed the door again for one minute. Thereafter, ██████████ opened the door and left it open, presumably allowing for the Service Recipient to be at liberty to leave the bedroom thereafter. (Justice Center Exhibit 30)

### 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 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.

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- (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.

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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 “Offense 1” in the substantiated report. The act committed by the Subject, namely, dragging a Service Recipient by his arms to his bedroom, constitutes abuse. The category of the affirmed substantiated abuse that such act constitutes has been changed from Category 2 to Category 3.

The Justice Center has not established by a preponderance of evidence that the act described as “Offense 2” in the substantiated report, of shutting the Service Recipient in his bedroom and then holding the door shut so that he could not exit, constitutes neglect.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-30) The investigation underlying the substantiated report was conducted by OCFS Child Abuse Specialist, ██████████ ██████, who was the only witness who testified at the hearing on behalf of the Justice Center.

██████████ testified on his own behalf and provided no other evidence.

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 30)

With respect to “Offense 1,” the substantiated allegation, that ██████████ dragged a Service Recipient by his arms to his bedroom, it is incontrovertibly clear from the video that ██████████ did commit the act of dragging the Service Recipient across the floor by his hands. (Justice Center Exhibit 30)

██████████ testified at the hearing and provided a signed statement that he had only “pulled” the Service Recipient across a smooth floor surface, for a short distance, and for the sole purpose of relocating the Service Recipient to his nearby bedroom to prevent him from being targeted by the other residents, as ██████████ had seen happen before. (Testimony of ██████████; Subject)

Although the physical intervention used by ██████████ appears to be relatively benign; the Service Recipient was already in a prone position on the floor and the dragging occurred for a duration of only ten seconds, the fact remains that the Service Recipient was subjected to an act of “physical abuse,” as defined in SSL§488(1)(a). In this case the physical abuse was the “...conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical...condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to... dragging...” as specified in SSL§488(1)(a).

██████████ dragging of the Service Recipient was not consistent with the Service Recipient's Individual Treatment Plan. The Service Recipient's *Individualized Crisis Management Plan, Enhanced Program* contains a list of “*Intervention Strategies - What has happened in the past and possible future strategies.*” Suggested interventions include offering rewards, offering choices and redirection. The dragging of the Service Recipient along the floor to his bedroom, or for that matter, the use of any type of physical interventions, are not listed as suggested intervention strategies of the Service Recipient's *Crisis Management Plan*. (Justice Center Exhibit 5)

██████████ dragging of the Service Recipient was also not consistent with generally accepted treatment practices. ██████████ testified that he had received training in Therapeutic

██████████  
Crisis Intervention, among other trainings, as a Child Care Worker. (Testimony of ██████████  
██████████; Subject)

██████████ had received certification of successfully completing the *Therapeutic Crisis Intervention Refresher* program on ██████████. (Justice Center Exhibit 13)

In short, ██████████ was clearly aware of generally accepted treatment practices.

The Justice Center provided some relevant pages of a *Therapeutic Crisis Intervention (TCI) Student Workbook*, which deals with crisis management for children and young people. (Justice Center Exhibit 29)

There are many directives and policies contained in the workbook, some of which would be applicable in this case. Under the heading “*MODEL POLICY FOR USE OF PHYSICAL INTERVENTION,*” it states that:

Except where otherwise as specified as part of an approved individual crisis management plan, physical intervention should only be employed as a safety response to acute physical behavior and their use is restricted to the following circumstances: The child/young person, other clients, staff members or others are at *imminent risk of physical harm*. (Justice Center Exhibit 29) (Emphasis added)

Under SSL§488(1)(a), “Physical abuse shall not include reasonable *emergency interventions necessary to protect the safety of any person.*” (Emphasis added)

██████████ testified at the hearing that his conduct was the best way of diffusing a potentially dangerous situation that could have quickly become violent and that his actions were necessary and effective as “... all the kids were safe. No one got hurt.” (Testimony of ██████████  
██████████; Subject)

██████████ testimony regarding the exigency for intervention is not credited evidence as it was uncorroborated. The video shows that, at all pertinent times, the Service Recipient was either sitting or lying on the floor, relatively far from the other Service Recipients. There was no

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evidence whatsoever in the hearing record of any threats being made, either physically, with gestures, or verbally. Accordingly, it is determined that, at the time that ██████████ dragged the Service Recipient by his hands, there was no *imminent risk of physical harm* to any person, nor were *emergency interventions necessary to protect the safety of any person*.

In the final analysis, after considering all of the evidence, it is concluded the Justice Center has met its burden of proving by a preponderance of the evidence that the act committed by ██████████, of dragging the Service Recipient by his hands across the floor, constituted a “physical abuse”, as alleged in the substantiated report. ██████████ dragging of the Service Recipient could have easily resulted in an injury to the Service Recipient and therefore caused “...the likelihood of serious or protracted impairment of the physical...condition of a service recipient...”

Although the report will remain substantiated, the next question to be decided is whether the substantiated allegation constitutes the category of abuse as set forth in the substantiated report. Under 14 NYCRR § 700.6 (a), the ALJ has discretion to amend the findings of the substantiated report since it is the subject matter of the hearing, namely, “whether the findings of the report should be amended.” Section 700.6(b) specifically sets forth the category of abuse or neglect as one of the three issues to be determined at the hearing. Taking into account that ██████████ ██████████ act of “physical abuse” did not cause any injury, and, in fact, was not even remembered by the Service Recipient and that ██████████ motivation was the protection of the Service Recipient, it is determined with respect to “Offense 1” that the category of abuse is hereby amended to be a Category 3 act.

With respect to the remaining allegation, namely, “Offense 2,” the Justice Center did not establish by a preponderance of evidence that ██████████ actions constituted neglect.

██████████

The video reveals that after ██████████ dragged the Service Recipient into his bedroom, he exited the room and closed the door after himself. ██████████ then stood outside the closed bedroom door for one minute and thirty eight seconds. ██████████ then opened the door and went into the bedroom, apparently to speak to the Service Recipient, and remained with him for one minute and fifty seconds. ██████████ then exited the bedroom, closed the door and stood outside the room again, this time for one minute. Thereafter, he opened the door and, by all accounts, the incident was over. (Justice Center Exhibit 30)

Some of the witnesses provided signed statements that ██████████ had held the door shut when it was closed. Other witnesses did not observe that ██████████ had held the door shut. It is difficult to see clearly from the video whether or not ██████████ was holding the door shut. In any case, the Service Recipient was kept for a very short period of time confined to his bedroom, a place of safety, with ██████████ right at the door, monitoring the situation.

In this case, ██████████ employed one of the recommended intervention strategies of the Service Recipient's Crisis Management Plan, that of having the Service Recipient "redirected from peers and brought to area with less stimuli." (Justice Center Exhibit 5)

██████████ conduct was not likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of the Service Recipient and, therefore, did not constitute neglect.

Accordingly, the substantiated allegation of "Offense 2," that ██████████ committed an act of neglect, is hereby reversed.

Also, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that ██████████ committed the abuse alleged in "Offense 1" of the substantiated report, amended to be a Category 3 act, that is the subject of the proceeding.

██████████

A substantiated Category 3 finding of abuse or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496 (2). This report will be sealed after five years.

**DECISION:**

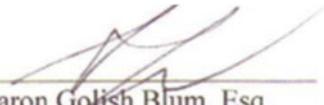
The request of ██████████ that the substantiated report dated ██████████ ██████████, ██████████, dated ██████████ be amended and sealed is denied with respect to the allegation that that he dragged the Service Recipient by his hands, along the floor, the Subject has been shown by a preponderance of the evidence to have committed physical abuse.

The request of ██████████ that the substantiated report ██████████ ██████████ dated ██████████ be amended and sealed is granted with respect to the allegation that he committed neglect by shutting a Service Recipient in his bedroom and then holding the door shut.

The substantiated report is amended to be a Category 3 act.

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

**DATED:** January 28, 2015  
Plainview, New York



Sharon Golish Blum, Esq.  
Administrative Law Judge