

## STATE OF VERMONT

## HUMAN SERVICES BOARD

In re ) Fair Hearing No. 12,871 &

) 12,944<sup>(1)</sup>

Appeal of )

)

INTRODUCTION

The petitioner appeals the decision by the Department of Aging and Disabilities "substantiating" four reports of abuse against the petitioner involving two disabled adults under his care at a community-based residential facility. The petitioner seeks to have the reports destroyed and not entered on the Department's "registry".

FINDINGS OF FACT

The petitioner was employed as a "support person" at a community based intermediate care facility (ICF) for multi-handicapped adults. Prior to this employment the petitioner worked with mentally retarded adults at the Brandon Training School. Prior to the incidents in question the petitioner had worked at the ICF for eight or nine months and had received "excellent" reviews of his work from his employer.

On January 31, 1994, one of the petitioner's co-employees at the ICF observed the petitioner forcefully lead one of the residents at the facility into the dining room and push her onto a day bed. When the resident stood up the petitioner pushed her back down. This happened three times in rapid succession. The third time the resident's head struck the wall behind the bed when the petitioner pushed her down onto it.

The petitioner testified that on the day in question the facility was short-staffed, and that he had been attempting to assist two residents with their meal when both residents began throwing their food. Since the "protocol" at the ICF was to "block" such behavior, the petitioner felt the only way he could do so was to remove one resident from the table and have her sit on the day bed while he fed the other one. The petitioner denies pushing the resident onto the day bed, and alleges that the resident hit her head on the wall after she threw herself onto the bed.

The hearing officer deems the testimony of the employee who witnessed the incident in question to be credible. Moreover, several employees at the facility testified that the overall protocol at the facility was for staff to remain calm with the residents and to never use excessive or unnecessary force in deterring

inappropriate behavior by residents. It is found that although the petitioner was in a stressful situation at the time, he used excessive and unnecessary force in removing the resident from the table and repeatedly pushing her onto the day bed.

The next day, February 1, 1994, the same employee who had witnessed the prior day's incident was at the dining room table assisting a resident with her noon meal while the petitioner was sitting with another resident (the same one he had pushed the day before) attempting to help that resident with her lunch. The employee testified that when the resident the petitioner was helping began grabbing items on the table (a behavior she frequently engages in) the petitioner became angry, yelled at the resident, and pushed her chair away from the table. The resident then stood up and flipped her plate over. The petitioner attempted to push her back into her chair, but the resident ended up falling to the floor. At this point the petitioner abruptly led the resident out of the room, ending any attempt to give the resident her lunch. Later, the employee who was sitting at the table took it upon herself to feed the resident a snack.

The petitioner testified that the resident threw herself onto the floor when he placed his hands on her shoulders to try to get her to sit back down in her chair. The petitioner denies yelling at the resident. He stated that he believed the resident didn't want to eat, and that, therefore, he discontinued his attempt to help her with her lunch.

Another staff member who was present in the room at the time testified that although she did not see the petitioner push the resident, she heard, and was upset by, the petitioner's verbal "anger" toward the resident. Several employees of the facility testified that it is never appropriate to deny a resident a meal because of disruptive behavior, and that it is essential that staff remain calm with residents. Again, the testimony of the witnesses who observed this incident is deemed credible. It is found that the petitioner used excessive verbal and physical force with the resident in question and improperly denied her a scheduled meal.

The next day, February 2, 1994, two employees of the facility observed the petitioner using what they considered to be excessive force in brushing another resident's teeth. One testified that the petitioner had the resident in a headlock and was forcefully brushing the resident's teeth while the resident vociferously protested. The other employee testified that she saw the petitioner forcefully holding the resident's chin with one hand while he brushed her teeth with the other. They and another employee

observed that the resident was upset and that her mouth was bleeding when she came out of the bathroom.

Several employees testified that this resident is very tactilely sensitive, and that great care and patience must be taken in brushing her teeth. The established protocol for this at the facility is have the resident be sitting down, to stop whenever she gets agitated, and to resume when she calms down.

The petitioner denied that he used excessive force in brushing the resident's teeth that day. He admitted, however, that he was aware of the protocol, but that he disagreed with it. He stated that in his opinion the best way to brush that resident's teeth was to "do it and get it over with". Again, however, the testimony of the employees who witnessed the incident is deemed credible.

On February 4, 1994, another employee of the facility observed the petitioner angrily and forcibly remove a resident (the same one that had been involved in the tooth brushing incident) from the kitchen where he was working, and push her into a chair in the living room. The employee testified that it was in

this resident's "program" that she be allowed to go in the kitchen as long as a staff member was present.

The petitioner testified that he was in the kitchen preparing dinner and that the resident was grabbing food off the counter. He stated he ushered the resident out of the kitchen and tried to get another staff member to engage her so that he could get his work done. Based on the evidence presented, however, it is found that the petitioner used inappropriate and unnecessary physical force with this resident.

During the period that the above incidents occurred the supervisor of the facility was on personal leave. After two other employees had declined, the supervisor had assigned the petitioner the responsibility of being in charge of the facility in his absence. The staff people who had witnessed the above incidents called the supervisor at home a few days after the incidents had occurred. The supervisor advised them to put their allegations in writing, which he then turned over to the personnel director of the agency that runs the facility. These allegations led to an investigation by the Department, which resulted in the action that is the subject of this appeal. The petitioner was terminated from his employment as a result of the allegations.

Except for the two employees who both witnessed the lunchtime incident on February 1, 1994, and who later spoke with each other before notifying their supervisor, the employees who witnessed the four incidents described above each reported those incidents to their supervisor without the knowledge of the others' reports. The petitioner alleged that two of the employees had reason to be biased against him, but he did not impugn the motives of the others who made complaints and who testified at the hearing. To discredit all the witnesses' testimony in this matter would infer a conspiracy against the petitioner that is in no way discernable from either the evidence or the demeanor of those witnesses. The petitioner's supervisor admitted that he was "surprised" by the allegations, but that he had no reason to disbelieve any of the reports in question. As noted above, the testimony of all the witnesses to the incidents in question struck the hearing officer as credible.

There is no indication that the petitioner intended any bodily harm to the individuals in question, or that any of those individuals suffered any ill-effects beyond the immediate time the incidents occurred. The evidence establishes, however, that the petitioner's actions upset the residents and exacerbated the anxiety and negative behavior they were demonstrating at the time. The evidence establishes that the petitioner used physical and verbal force and intimidation against the residents in question that was in excess of what he knew or should have known was appropriate under the circumstances.

The evidence is clear that the petitioner knew or should have known that the profound disabilities and vulnerability of these individuals require patience and gentle handling on the part of their caregivers at all times. It is found that the petitioner's pushing, yelling at, and denying a meal to one resident and his forcefully holding the head of another resident while brushing her teeth, and his forcible removal of that resident from the kitchen and pushing her into a chair, was contrary to those residents' needs and welfare, and caused those residents unnecessary harm, pain, and suffering.

#### ORDER

The Department's decision "substantiating" the report of abuse by the petitioner is affirmed.

#### REASONS

The Commissioner of the Department of Aging and Disabilities is required by statute to investigate

reports regarding the abuse of elderly and disabled persons and to keep those reports that are "substantiated" in a "registry" under the name of the person who committed the abuse. 33 V.S.A. §§ 6906 and 6911. Within 30 days of notification that a report of abuse has been substantiated against them individuals can apply to the human services Board for a fair hearing on the grounds the report is unsubstantiated. Id § 6906(d). Reports that are found to be unsubstantiated must be destroyed pursuant to 33 V.S.A. § 6906(e) and not entered in the Department's registry.

33 V.S.A. § 6902 includes the following definition:

As used in this chapter:

(1) "Abuse" means:

(A) Any treatment of an elderly or disabled adult which places life, health or welfare in jeopardy or which is likely to result in impairment of health;

(B) Any conduct committed with an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain or unnecessary suffering to an elderly or disabled adult;

(C) Unnecessary confinement or unnecessary restraint of an elderly or disabled adult;

(D) Any sexual activity with an elderly or disabled adult by a caregiver, either, while providing a service for which he or she receives financial compensation, or at a caregiving facility or program;

(E) Any pattern of malicious behavior which results in impaired emotional well-being of an elderly or disabled adult.

The above statute is intended to provide extraordinary care and protection to elderly and disabled individuals and to set a particular standard of treatment for those individuals' caregivers. See *Id.* §§ 6901 and 6902(2) and Fair Hearing Nos. 12,187 and 9,716. Although the petitioner's actions in this matter are not as egregious as some the Board has seen, based on the above findings it must be concluded that the petitioner's treatment of the disabled adults in his care placed their welfare in jeopardy and recklessly caused those individuals unnecessary harm, pain, and suffering within the meaning of paragraphs (A) and (B) of the above statute.

The petitioner knew that the well-being of those individuals required that they not be subject to rough, coercive, and intimidating handling by their caregivers. The evidence establishes that on at least four separate occasions the petitioner violated those requirements by using unnecessary and inappropriate physical force on two residents of the facility where he was employed. The Department's decision "substantiating" the petitioner's "abuse" of those residents should, therefore, be affirmed. <sup>(2)</sup>

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1. Following the petitioner's first request for fair hearing the Department conducted a "Commissioner's Review" of the matter. Following this review the petitioner again requested a fair hearing, to which the Board assigned a new docket number. However, both requests concern the same events and essentially the same decision by the Department.

2. The petitioner also argues that because the reports of abuse weren't made to the Department within 48 hours, as required by 33 V.S.A. § 6903, the charges against him should be dismissed. As noted above, however, the statutes in question are intended to protect victims of abuse. This provision cannot reasonably be interpreted as exonerating an alleged perpetrator of abuse solely because the reporter of that abuse did not comply with the timeliness provisions of the statute.