

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 13,180

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Appeal of)

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INTRODUCTION

The petitioner appeals a decision by the Department of Aging and Disabilities substantiating a report of abuse against the petitioner involving an elderly resident of a nursing home where the petitioner was employed.

FINDINGS OF FACT

1. The petitioner, who is a licensed practical nurse, was an employee of a nursing home providing high levels of care to elderly and disabled patients. On the evening of September 12, 1993, the petitioner was the charge nurse on the evening nursing shift. (3:00 to 11:00 p.m.)
2. Just before the shift was to change at 11:00 p.m., an elderly resident, W.D., emerged from his room without any clothing on. W.D. is eighty-seven years old, weighs 139 pounds and is sixty-five inches tall. He has severe cognitive impairments, Alzheimer's dementia, depression and physical problems (chronic foot pain) as well as eating and sleeping disorders. He had only been a patient for a short time.
3. At the nurses' station at that time were three aides who were going off their shift, Amy, Tina and Fran, two aides who were taking over the shift, Ursula and Lynn, and the two charge nurses, the petitioner, who was leaving, and Karen, who was arriving. The charge nurses were sitting together going over records in an area just out of sight of the hall. Amy and Lynn were positioned so that they saw W.D. come into the hall from the nurses' station some sixteen feet away. Much testimony, not all of it consistent in detail, was offered as to what occurred next from each of the eyewitnesses. A summary of each eyewitness is as follows:
 - a. Amy stated that D.W. crossed the hall and went into one patient's room then crossed back and went into a sleeping woman's room next door to his room. Amy and Lynn went to that room and asked him to leave. He loudly refused to do so and refused to be led by the hand. Amy left the room so that Lynn

could talk quietly with W.D. about leaving. Ursula seeing what was happening came to assist and handed Lynn a "johnny" and then went to get a "geri-chair". W.D. finally was persuaded to come into the hallway where he was speaking loudly and swearing. Although he was noisy, agitated and swinging his arms, he did not wake anyone and did not pose a real threat to anyone other than himself. Amy and Lynn tried to get him to put on a johnny gown but he refused. Ursula arrived with the "geri-chair" and they tried to persuade him to sit down to no avail. Amy, leaving the matter to Lynn and Ursula, went back to the desk where Tina was standing and the two prepared to leave. Another aide named Fran was also standing there. At that point the petitioner, hearing all of the noise in the hallway, got up from her desk, strode down the hall and said to Ursula and Lynn, "I'll show you how to deal with a patient like this." Amy saw her grab both of W.D.'s wrists and "slam" him into the geri-chair and put a table over him. The petitioner then stepped on his feet to keep him from kicking. Amy told the petitioner that she did not think it was appropriate to treat a patient that way. Disturbed by what they had both seen, Amy and Tina discussed the incident as they were leaving their shift and decided to report it to the nursing supervisor in the morning.

b. Ursula testified that she did not see the beginning of the incident but heard the noise W.D. was making. She said Amy returned to the nurses' station and said she was having a difficult time getting him dressed. Ursula then went to see if she could help. She got a johnny and went to get the "geri-chair". She stated that W.D. often threatens and gets angry but responds to calm discussion and felt she could persuade him to leave the sleeping woman's room into which he had wandered. She went in the room where the door had been closed and helped Lynn to coax him into the hallway. They gently held his hands and dropped them when he shrugged them off. She planned next to coax W.D. to sit in the geri chair but before she could do so, the petitioner came down the hall, followed closely by Karen the night charge nurse, and said "I'll show you how to handle this person." She then grabbed W.D. by the wrists who became angrier and he started to fight her. As Ursula stood nearby she saw the petitioner force W.D. to turn around and then push his arms firmly down until he was forced to sit in the chair and then saw the table put down in front of him. She then saw blood on his wrists and one of the aides went to get him something to drink. The next morning, she reported the incident to the nursing supervisor because she felt it was wrong to have taken hold of him in that way. Her written report stated that his "arm" was bleeding. Ursula stated that it should have read that his "arms" were bleeding as both were involved. Her report was not prompted by any animosity toward the petitioner whom she stated she liked and got along with well. She also denied being reprimanded by the petitioner for inadequate performance in the past.

c. Tina testified that on the night in question she had been standing at the nurses' station preparing to leave her evening shift when she saw W.D. walking in the hallway (fifteen to twenty feet away) with no clothes on behaving in an agitated manner. She saw two aides, she could not recall which ones, trying to put a "johnny" on him with no success and recalled that W.D. was making a lot of noise and swearing at people, behavior which was not uncommon for him. She saw him go into a room but could not recall if he shut the door. She also saw the aides touch his arm to try to get him to leave the room but he shrugged off their attempts to lead him. The petitioner, who was sitting near her in the nurses' station, became angered by the noise and forcefully put down the books she had been working on and started down the hall saying in an angry tone, "Let me tell you how we take care of these people." She walked quickly down the hallway, followed by Tina who came about ten feet closer to watch where she saw the petitioner grab W.D. by the arm, twist him around and push him into his chair and hold him there, "longer than was needed." She does not recall seeing Karen, the night charge nurse, in the vicinity. She reported what she had seen to the nursing supervisor the next morning because she felt there was excessive force used and that the procedure used was contrary to the policy of calming patients, retreating from confrontation and retrying again in a few minutes. She had never seen anyone at the

nursing home push a patient into a chair before that evening. The next day she saw dark bruises on his wrists and a cut near his watch. She had not seen these injuries the day before when she had cared for W.D.

d. Karen testified that she was at the nurses' station a few minutes after the start of the 11:00 p.m. shift and that she was preparing to take over as the shift charge nurse. She was sitting at a desk going over some reports with the petitioner and heard the aides in the hallway trying to coax W.D. out of a room. She looked for the records to see if the petitioner had received his Haldol medication. As the noise became louder, she said the petitioner became distracted and got up from the desk and moved toward D.W. Karen followed her and heard her say, "Now I'll show you how to deal with this." She observed the petitioner grab W.D. by the wrists and saw W.D. try to resist and push her away. Karen was surprised at the force the petitioner was using and put her arm under W.D.'s armpit to block him from swinging at the petitioner. The petitioner sat W.D. down hard in the chair and continued to hold on to his wrists while someone brought a table top to lock him in. Karen then brought W.D. to the dining room and cleaned him up and let him cool down. She observed bruises forming in the area where the petitioner had held his wrists. She felt the force was excessive for the situation because, although W.D. was agitated, it was her experience that he was easily distracted and could be defused and calmed without force.

Karen did not speak further to the petitioner about the matter but reported her to the nursing supervisor the next day. Beginning that afternoon, she says that the petitioner left a series of five messages on her answering machine in which the petitioner asked her in an angry and threatening voice if she was "up to par" herself and asked her if she "felt intimidated" by her phone calls. Karen agreed that the petitioner had frequent criticisms to make about her patient care and had claimed the day before that she had given too much medicine to a patient. Although they do not get along well, Karen denied reporting the incident as an act of revenge but rather because she is required to report bruises and other injuries to patients which occur when she is the shift charge nurse.

e. Lynn, who has been a nursing aide for ten years and was certified as such in the last two years, testified that she was coming on to her shift a few minutes before 11:00 p.m. when she saw W.D. in the hallway in his boxer shorts which he then removed. She tried to persuade him to put on a johnny but he refused and was talking loudly. He then walked into the room next to his and Lynn went in with Ursula to coax him out. She said that she had successfully coaxed him into putting on the johnny and coming out of the room and planned to coax him into a geri-chair which had been brought into the hall. She and Ursula were holding hands with W.D. in the hallway. She denied pulling on his hands or arms in any way. At that point, she said the petitioner "stormed" quickly down the hall and said in an angry and upset way, "I will show you how to handle these kinds of people." She observed the petitioner grab W.D.'s wrists over the top, hold them "tightly" until her knuckles turned white and saw the petitioner turn him "roughly" around and push him into the chair. W.D. was fighting her while she was doing this. Lynn said such rough treatment was against procedures and unnecessary in this case as she knows W.D. and knows that he does not harm people unless he is provoked. She observed after the incident that his arms were bruised and very red. She reported the incident to the nursing supervisor the next morning.

f. Fran, another aide, was at the nurses's station preparing to go off duty during the shift change and observed W.D. taking off clothes and going in and out of rooms. She originally went down the hallway and tried to get W.D. to put on some clothes but was unsuccessful. She turned the task over to two aides, Ursula and Lynn, who were coming on duty and returned to the nurses' station. W.D. was making a lot of noise and after a few minutes she observed the petitioner, who was sitting nearby at a desk, "slam"

down the books she had been using and go into the hallway saying firmly and in a loud voice, "I'll show you how to handle these people." She then saw the petitioner grab W.D. by the wrists and push him into a chair. She was surprised by this action because it is against the policy of the facility to use physical force on patients. She also observed that Karen went with the petitioner to help her. She did not report the matter the next day but was approached by the management and asked to write a statement of what occurred because she had been an eyewitness to the event. She did not believe there was any reason to use physical force on W.D. to get him to cooperate.

g. The petitioner who has been an L.P.N. for almost nine years and who has worked at this nursing home as a per diem nurse off and on since 1987, testified that as shift charge nurse, she was responsible for sixty-one patients on the first and second floor, most of her patients were elderly and in need of high levels of care, particularly those who lived on the first floor, as did W.D., three quarters of whom suffered from Alzheimer's disease. She agreed that it was the policy of the nursing home to treat these patients in a quiet, reassuring manner with structure and simple directions from one person at a time. She stated that she always followed this policy. She recalls that at about 11:00 on the evening of September 12, 1993, she was going through the records during a shift change with Karen, another L.P.N. who had only been working for four months, who was about to take her place. She remembers that Lynn and Ursula were coming in to work and that Amy and Tina were at the nurses' station preparing to leave. She says that she observed W.D. down the hall standing nude in a doorway and posturing to void against the wall, as he sometimes did. She saw Tina and Amy walk toward him while one stopped to get a johnny. One aide was "yelling" at W.D. that he could not do that. She continued to give her report to Karen while aides assisted him and she did not see what happened next. She heard a door slam, looked down the hallway and saw Amy and Tina standing in front of a doorway and saw part of W.D. from the side standing nude in a doorway. She next saw Tina and Amy coming down the hallway toward her with one "swinging a johnny" and saying "I give up." She believed that at that point W.D. was in the room of a female patient with the door closed. Karen said something to them and came back to the station to look for W.D.'s Haldol order. The petitioner, who felt she knew W.D. better than Karen, said at that point, which was ten minutes after W.D. was first discovered in the hallway, "Let me show you how I work with this resident." At that point, W.D. was still inside the room and Tina was trying to push the door open. She saw W.D. back out of the room in which he was sitting, hit the back of his right hand on a latch plate and cut it and then close the door. She alleges that she then said, "I'm a nurse, do you have to urinate, let's go to your room and get dressed." To which he responded, "Where's my wife?". After reassuring him that she was home in Brattleboro and letting him know it was nighttime, he became very quiet and just stood there. Tina, Amy, Lynn and Ursula were all standing there. She stated that he agreed to go to his room and that she stood opposite him and placed her arms under his arm to guide him into the chair which another aide had brought. As she took his arms, she asked "Would you like to sit down" and she remembers that he said, "yes." She then guided him into the chair with his hands resting on her forearm. She denies that there was a struggle or that any force was used and specifically denies grabbing W.D. by the wrists, arms or hands. He did not resist sitting down but was hesitant when the back of his chair hit the calf of his leg. She held on to his forearm until Lynn brought the table. Then she went to wash the blood off her hands from the tear on his skin and advised everyone else to do the same. She returned to her charting and shortly thereafter left for the evening after mentioning to Karen that she should address W.D.'s skin tear.

The petitioner is aware that her testimony is inconsistent with that of the other six eyewitnesses. She believes that the others fabricated their evidence because she has criticized each of their work performances and because they are jealous of her job experience, good pay and enjoyment of her work. The criticisms she has had of them have ranged from failing to keep patients clean to giving the wrong

dosages of medication. She has seen the bruises on W.D.'s arms and believes they were caused by the aides pulling him out of the room. She also believes that the bruising could be caused by "senile purpura" which causes arms to look red purple at times. She believes she had seen this on W.D. before although she could present no evidence that he has this disease. She agrees that she called Karen after the incident and told her something to the effect that she needed to "look at her own skills and clean up her act" and also that Karen had better get this straightened out or she would report her to the Nursing Board. She also agreed that she made some calls to staff members at work but did not make further calls after being requested to refrain from doing so by the nursing home administrator. She stated that she was upset because she had lost her job and had not had an opportunity to tell her side of the story before it had happened.

4. The Director of Nurses at the nursing home both received and solicited written reports from staff members who witnessed the petitioner's actions with W.D. during the 11:00 p.m. shift change on September 12, 1993. After viewing the bruises on W.D.'s wrists and discussing the reports with the administrator, she determined that the petitioner had used inappropriate force with W.D. under the nursing home's policy. She characterized that policy as requiring quiet persuasion and the avoidance of physical confrontations with patients absent the existence of an emergency situation, such as the need to protect another patient or staff member from imminent harm. She did not see the need to remove a nude man from the room of a sleeping female nor loud protestations from a nude man in the hallway as an emergency situation requiring the use of force. She determined, along with the administrator, to discharge the petitioner from her duties and called her that afternoon to tell her not to report for her three o'clock shift.

5. Following the petitioner's discharge, the administrator of the home called the Department of Aging and Disabilities to report the incident. He also called the petitioner and asked her not to call other staff members at work to talk with them, as he understood she was doing. (He had not spoken with the petitioner before deciding to discharge her.) He noted that she had no prior record of mishandling patients at the facility. Four days after the incident, he met with W.D. to observe and take pictures of his injury. The administrator identified pictures placed into evidence as pictures of W.D.'s left arm which were taken that day. Photos of the right arm were taken but could not be put into evidence because of their poor quality, he testified, and the petitioner agreed, that there was a tear on W.D.'s right arm. That picture shows deep red bands of bruising on the petitioner's upper left hand just below his watch and some bruises farther up on his left arm. The administrator refused to produce his medical records and records on other employees at the nursing home on the basis of confidentiality. The petitioner though advised that she could attempt to enforce her subpoena through the Superior Court under the APA, did not take that action.

6. This matter was investigated by the Department of Aging and Disabilities pursuant to a report made on September 14, 1993. The investigator spoke with each of the witnesses who testified at the hearing and gathered written statements from each. She also talked with W.D. and his wife on September 16, 1995 and observed his bruises. W.D. was unable to describe the incident due to his illness. She spoke as well with the state nursing home licensing investigator. She tried to meet three times with the petitioner but the petitioner was unable to do so. They did speak by telephone and the investigator was referred to her attorney who orally gave the investigator her version of the story. She also looked at the complaint record against the petitioner and found no history. She did not look at complaint records regarding the eyewitnesses.

7. It was the investigator's decision based on all of the evidence that W.D. was bruised by the petitioner

holding his wrists with excessive force during a struggle and that there was no justification for such force. She also determined that the petitioner had violated standard practice of coaxing a patient into a chair and had instead pushed the petitioner into the chair. On September 22, 1994, the patient was notified that she was found to have abused an elderly patient. The investigator rejected claims that other aides had caused the bruising by pulling W.D. out of his room as being against the weight of the evidence.

8. Based on all of the above evidence it is found herein that the petitioner, while in a position of trust with regard to an elderly man, W.D., approached him in an angry manner, grabbed his wrists, struggled with him, twisted his body around and pushed him into a chair where he was restrained first with her arms and later with a tray placed on the chair by another aide. It is also found that the petitioner grabbed his wrists so tightly that such grabbing resulted in deep red bruise marks on both hands and forearms which were visible for several days thereafter. The vast weight of the evidence of six eyewitnesses support this finding and contradict statements by the petitioner that she did not use force and that bruises were the result of the action of other aides. The evidence does not support a conclusion that the witnesses manufactured facts or conspired together to manufacture facts due to a bias against the petitioner. The inconsistencies in the testimony of the eyewitnesses did not generally involve the essential facts and served to confirm that the witnesses had not rehearsed their testimony beforehand, but were rather independently recalling their observations of the event.

ORDER

The decision of the Department of Aging and Disabilities finding that the petitioner abused an elderly man is affirmed.

REASONS

The Commissioner of the Department of Aging and Disabilities is required by statute to investigate reports regarding the abuse and exploitation 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.

The statute which protects elderly and disabled adults, 33 V.S.A. § 6902, defines "abuse", in pertinent part,

as follows:

(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;

...

The evidence shows that the petitioner acted in an angry and uncontrolled manner to restrain an elderly adult and in the process of doing so, bruised his wrists and arms, pushed him roughly, and caused his dementia-induced agitation to increase. The petitioner's actions resulted in pain and disfigurement and placed him at a greater risk of harm both due to the roughness with which he was treated and the rough physical reaction it provoked in him. The evidence shows that the restraint and the force were neither accidental nor necessary. No emergency existed which might have justified such an action. On the contrary, the situation appeared to be under control. The petitioner's intervention exacerbated the situation and put the elderly man at grave risk.

Given these facts, it must be concluded that the petitioner's actions on the evening of September 12, 1993, constituted abuse under all three definitions found in the protective statute above. The Department's decision to substantiate abuse should be affirmed and the Department should be authorized to place the petitioner's name on the

abuse registry.

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