

STATE OF VERMONT

HUMAN SERVICES BOARD

In re ) Fair Hearing No. 18,471  
 )  
Appeal of )

INTRODUCTION

The petitioner appeals a determination of the Department of Aging and Disabilities (DAD) that she abused an elderly person.

FINDINGS OF FACT

1. Until January of 2004, the petitioner was a licensed nurse's aid at a long-term care facility. She had worked in that facility since 1999.

2. In late October and the beginning of November 2002, the petitioner worked the third shift from 11:00 p.m. to 7:00 a.m. at the long-term care facility. She frequently worked with another licensed nurse's aid, C.H. C.H. had been working at the same facility for about two years and had worked with the petitioner for about a year at that time. The petitioner and C.H. did not know each other socially outside of the nursing home. They had a cordial working relationship.

3. C.H. testified that she witnessed three incidents that were of concern to her in late October or early November of 2002. The first incident involved a ninety-two-year-old

woman, T.B., whom she heard screaming in her room as she passed by in the hallway. She heard the petitioner's voice coming from the room saying "knock it off" and "push over". She went into the room to offer the petitioner her assistance. She found the petitioner forcefully pushing T.B. to the other side of the bed. Although she described T.B. as a "cryer", C.H. said that her scream at this time was an unusual one of pain and fear. Her crying stopped when C.H. joined in to help the petitioner. She started to observe the situation more closely over the following few days and saw that T.B. would start screaming in fear whenever the petitioner went into her room. She also observed that the petitioner would go into T.B.'s room while she was sleeping and turn her over without awakening her and announcing what she planned to do.

4. Another evening a few days later, when only C.H. and the petitioner were working on the floor, C.H. said she heard through a wall in an adjoining room that the petitioner was screaming at B.C., an eighty-two year old woman. She said the petitioner screamed at the woman, "Stop yelling and shut up."

5. On another night during this period of time, C.H. and the petitioner were caring for an elderly man who was recovering from a shoulder injury and was unsteady on his feet. C.H. said that the man needed to go to the bathroom

frequently and rang the nursing station for aid. C.H. observed that the petitioner turned off the call light three times in fifteen minutes without answering the call. C.H. spoke to her about her actions and said that it was dangerous not to answer the call because the elderly man would try to go to the bathroom himself.

6. C.H. says she was upset by these incidents because they were not consistent with the nursing staff's duty to the patients and pondered what to do about it for two weeks. She finally reported the incidents to the charge nurse who told her she must report it to the Director of Nursing as possible patient abuse. C.H. did so on November 13, 2002.

7. The incidents were reported to DAD on November 18, 2002. DAD sent a registered nurse investigator to the nursing home where she interviewed C.H., the petitioner, the supervisors and the residents who were affected. The residents were unable to give her any information. The records of the witnesses and the petitioner were also reviewed. The investigator found that the petitioner had been reprimanded for failure to answer call lights two years earlier. The investigator decided that the petitioner has shown a "reckless disregard" for the welfare of her patients

and notified the petitioner that she was found to have abused these patients.

8. The petitioner says that the report was fabricated by C.H. although she could offer no motive for her to fabricate such a report. She says that she was not working at the nursing home during the times at issue although her further testimony showed that she was indeed working at the nursing home from October 28 through November 16, the time during which the incidents allegedly occurred. The petitioner denies not only that these events occurred but that the prior incidents in her file involving failure to respond to call lights had ever occurred although she agrees that she had received counseling on this issue.

9. The petitioner had a hearing before the Commissioner in the spring of 2003. At that time the Commissioner concluded that the allegations were founded and that the actions placed the welfare of the residents in jeopardy and were committed with an intent or reckless disregard that could cause unnecessary harm, pain or suffering.

10. The petitioner presented four written testimonials prepared by co-workers in the spring of 2003 attesting to the fact that they had never seen such behavior from the petitioner. However, the testimonials show that none of these

coworkers was on duty with the petitioner at the time of the alleged abuse.

11. The petitioner was originally allowed to continue to work at the nursing home pending the outcome of her appeal so long as she was accompanied in her duties by another LNA. However, she was discharged in January of this year for reasons unrelated to this particular finding.

12. The testimony of C.H. was found to be entirely credible because it was clear, consistent, based on direct observation, and totally lacked any motivation other than concern for the patients. The testimony of the petitioner lacks credibility because it was inconsistent and muddled. Based on this finding, the testimony set forth in paragraphs 3, 4, and 5 are found to be an accurate description of the incidents at issue.

ORDER

The decision of DAD is affirmed.

REASONS

The Department of Aging and Disabilities is charged by statute to protect disabled and elderly adults from abuse by investigating complaints and placing the names of those found to have abused such adults in a registry. 33 V.S.A. 6901,

6906(a), (b) and (c). Any person who is found by DAD to have abused a vulnerable adult has a right to appeal that decision to the Human Services Board where the burden is upon DAD to show that it had substantial evidence to find that an adult has been abused as that term is defined in the statute. 33 V.S.A. 6906(d).

DAD has met its burden of showing that the petitioner yelled insults at two patients, handled one of them roughly and carelessly, and failed to assist a third when asked for help. It showed that at least one of the patients appeared to be upset and frightened and another was placed in grave danger of falling by the petitioner's actions. DAD has concluded that these actions constitute abuse as it is defined in the statute because they were done with "reckless disregard" of the unnecessary harm, pain or suffering they might bring to the patients.

The statute adopted by the legislature defines "abuse", in pertinent part, as follows:

"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.

. . .

33 V.S.A. § 6902

The term "reckless disregard" has not been defined in the context of this abuse statute but has been defined in the Model Penal Code adopted by Vermont as follows:

A person acts recklessly with respect to a material element of an offense when he consciously disregards a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that, considering the nature and purpose of the actor's conduct and the circumstances known to him, its disregard involves a gross deviation from the standard of conduct that a law abiding person would observe in the actor's situation.

Cited in State v. Brooks 163 Vt. 245, 251 (1995)

The Board has held repeatedly that health care workers attending to the elderly and disabled are expected to adhere to a standard of conduct which shows respect for that vulnerable individual and which protects both the patient's physical health and emotional health. See Fair Hearing No. 15,190. Repeated insults and rough handling as well as neglect can undoubtedly lead to serious emotional and physical consequences. In the past, the Board has held that continued swearing at a patient, kicking a patient in the foot and pushing a patient all meet the definition of "reckless

disregard" for the health of the individual. Fair Hearing Nos. 15,190 and 17,932. In this case, the petitioner's colleague has testified credibly that the petitioner's treatment of her patients is grossly outside of the standard expected in the situation and that such treatment could lead to serious emotional and physical harm to the patients.

DAD was correct to conclude that under these circumstances the petitioner showed a "reckless disregard" for the harm that could come to her patients as that term is used in the statute. The Board should, therefore, affirm the substantiation made by DAD that the petitioner abused elderly or mentally ill adults in her care.

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