

he was the principal caretaker of the disabled adults on weekdays when he was not working.

2. In August of 2003, B.B., a young, mentally disabled adult, had a sudden need for a place to stay. B.B.'s case manager at the community mental health agency knew the petitioner because another disabled adult client, T.R., was already living in his home. The case manager asked the petitioner if he would take B.B. on short notice for a temporary trial. The case manager told the petitioner that B.B. was incontinent and needed plastic sheets and frequent laundry assistance. The petitioner agreed to take him although he was working out-of-town at the time of the call. The petitioner assured the case manager that C.H. and R.H., his respite assistants, would prepare his room and see to B.B.'s needs.

3. B.B. moved into the home the same day under the care of C.H., the assistant caretaker. At that time, the case manager observed that B.B.'s room had only a concrete floor and told C.H. that a rug had to be put into the room immediately. The room also needed drawers for clothing. The mattress and box spring were on the floor but were clean. The case manager gave C.H. an information sheet regarding the

petitioner which included the fact that he was incontinent and needed plastic sheets and frequent linen laundering.

4. About two weeks later, before the case manager had made his first follow-up visit, C.H. called the case manager to say there was an emergency and thereafter went to his office to give him the details. Following this conversation, the alarmed case manager and his supervisor went to the petitioner's home to see their clients. Under their protocols, they were escorted into the home by the police.

5. The case manager and supervisor went to B.B.'s room and found that no rug or drawers had been placed in it. The mattress was covered with feces stains, some of which appeared to be older and some that were obviously new. Feces were also all over the floor. The room smelled very bad. Dirty clothes were strewn throughout the room and the petitioner's bags had not been unpacked. There were no sheets on the bed and the case manager looked for but could not find any sheets in the washer or dryer.

6. With the assistance of the police, both B.B. and T.R. were removed from the petitioner's home. The petitioner was told that no further mental health clients would be sent to his home due to the state of the petitioner's premises. The petitioner's response was that it had been C.H.'s

responsibility to see to B.B.'s needs, not his, and that there had not been sufficient time for her to prepare the room for habitation. The testimony offered by the case manager in paragraphs 2, 3, 4 and 5 is found to be accurate and credible.

7. The Adult Protective Service division of DAIL investigated the incident by interviewing disabled adults, B.B. and T.R., their case managers, the caregivers C.H and R.H., the police and the petitioner. The investigator noted that R.H. was sixty-one years old (far older than the petitioner), appeared to be frail and may have had Alzheimer's disease. R.H. allegedly complained that the petitioner had refused to pay him as well as hitting him and knocking him to the ground. At the end of the investigation, DAIL notified the petitioner in a letter dated December 2, 2003, that it planned to place his name in the registry not only for neglecting B.B. (failure to provide or arrange for necessary services to maintain health), but also for abusing and neglecting T.R. (pattern of intimidation, emotional distress/failure to follow case plan) and for abusing and financially exploiting the caretaker, R.H. (pattern of intimidation, treatment which jeopardizes health, withholding of funds without legal authority).

8. The petitioner did not ask for an administrative review before the Commissioner and DAIL finalized its decision on April 2, 2004. In May of 2004, the petitioner appealed directly to the Human Services Board. The parties agreed to setting a hearing in August 2004 but then agreed to continue it when problems arose with obtaining witnesses, particularly R.H. and C.H. During this time, DAIL supplied the petitioner with all of the information it intended to rely upon at the hearing. The hearing was rescheduled in March of 2005 and completed in May of 2005.

9. T.R., a thirty-nine-year-old mentally disabled man who had lived with the petitioner for four or five months, testified at hearing through a room with a microphone and a one-way mirror. (This procedure was based on DCF's desire not to subject the petitioner to possible intimidation through direct face to face confrontation with the petitioner.) Although he was slow in answering, he clearly understood the questions (sometimes after clarification) and gave appropriate answers. He could not be persuaded to change or abandon his answers on cross-examination by the petitioner. He said that the petitioner was rarely at home. He said that he had originally lived in the "dungeon", referring to B.B.'s room, and that he did not get any

furniture other than the bed and a counter for his TV (the desk). He knew that he had lived there for more than a month and said that when the apartment was finished above the garage/barn, he went to live there. T.R. said that during his time at the petitioner's he had seen the petitioner hurt R.H. twice. The first was during a dispute about getting to an electrical box. R.H. grabbed the petitioner and then the petitioner pushed him off and knocked him against the wall. Then the petitioner punched R.H. in the face, knocking him to the ground causing R.H. to lose his wig and to be dazed. He heard R.H. threaten to sue the petitioner if he did that again. The second time he was in his apartment and saw R.H. and the petitioner outside on an upstairs deck. They were yelling at each other and he saw R.H. grab the petitioner and saw the petitioner hit R.H. on the side of the face on his bad ear with his fist. He saw C.H. run saying she would call the police and the petitioner running after her to unplug the phone. T.R. said he was scared by this but did not dare to tell anyone because the petitioner had told him that he would do the same thing to him if he told his case manager. The petitioner never hit T.R. but did push him out of the garage one time when he was angry and had been drinking. He agreed with the petitioner that R.H. could get in your face and be

scary when he was upset but said that R.H. had never grabbed him (T.R.).

10. T.R. further testified that once in a while he went out with the petitioner to play pool at a bar and that the petitioner sometimes asked him to drive back because he had been drinking too much. One time, he said the petitioner told him to drive a girl he met at the bar home without his supervision. Another time, he heard the petitioner say that he could get even with someone by injecting them with AIDS based on a formula he had seen on the internet. T.R. believed that the petitioner was serious when he said this.

11. T.R.'s case manager testified that he saw the petitioner weekly and was not aware of any particular problem with the petitioner until he was fully interviewed following the B.B. incident. T.R. told him while he lived in his house that the petitioner sometimes "got in his face" but that he liked the petitioner because he took him to bars and let him drive. T.R. had expressed frustration with wanting to spend more time with the petitioner. The case manager said that part of the plan for T.R.'s care was supervision with driving activities, a condition that had been asked for by T.R.'s guardian. He said that he advised the petitioner of this

requirement. The case manager's testimony was unrebutted and is found to be credible.

12. The petitioner admitted that he argued quite a lot with R.H. because R.H. was aggressive and hard to get along with. However, he denied ever striking him, except in self defense. He did not mean to hit him on his bad ear. He also denied ever withholding money from R.H. except with his wife's permission in order to modify his aggressive behavior.

13. The petitioner denied that he ever abused or neglected T.R. He said that he employed permission to drive the car as a method to encourage good behavior and added that T. R. had driven a girl home from the bar because he had liked the girl and wanted to take her home. He does not deny that T.R. witnessed physical altercations in his home but denies ever threatening T.R. with harm if he reported what he had seen to caseworkers. He says that his comments about HIV injections were not made to T.R. and were directed at another bar patron as a joke.

14. With regard to the treatment of B.B., the petitioner said he had hired C.H. and R.H. to care for B.B. as part of a caretaking team and feels that they should be held responsible for any deficits in his care. As he sees it, he should not be held responsible because he was not at

home when B.B. came to his house and DAIL knew that he was paying this couple to help him out. He did not deny that there had been feces in the room (although he questioned how long it had been there) and offered no explanation as to why the room had not been attended to or the luggage unpacked during the prior two weeks other than the fact that B.B. had been an emergency placement.

15. The testimony of T.R. and that of the petitioner are in conflict. Although not completely consistent, the testimony of T.R. is found to be credible with regard to his claim that the petitioner threatened him with harm if he reported what he had observed at the petitioner's home. It is also credible that he observed violent physical conflicts between the petitioner and R.H. and that he drove the car without supervision both when the petitioner was too inebriated to do so and when he was told to drive the girl home from the bar. T.R.'s testimony that the petitioner was rarely home or providing care or companionship himself to the disabled adults is also found to be credible. The petitioner's denials are found to lack credibility, particularly because he offered inconsistent testimony about his level of supervision ("we were a team" but "R.H. and C.H. were responsible" when things went wrong.), and his

insistence that he struck R.H. only in self-defense when the uncontroverted evidence was that R.H. was frail and smaller than the petitioner.

16. Both parties tried to find C.H. and R.H. in order to subpoena them. However, no one could discover their whereabouts and they were last believed to be residing in their car. Without the testimony of R.H. or one of his health providers, it cannot be concluded that R.H. was actually mentally or physically disabled or impaired.

ORDER

The decision of DAIL to place the petitioner's name in the registry of persons who have abused or neglected vulnerable adults is affirmed with regard to B.B. and T.R. However, all findings with regard to R.H. are reversed as unsubstantiated.

REASONS

DAIL is required to investigate complaints of abuse, neglect or exploitation of "vulnerable adults" and to substantiate such complaints if they are "based upon accurate and reliable information that would lead a reasonable person to believe that the vulnerable adult has been abused,

neglected or exploited". 33 V.S.A. § 6906, 6902(9). The perpetrators of any such complaints are given an opportunity to respond to the finding within fifteen days and, if the Commissioner determines that the substantiation should remain, an appeal may then be made to the Human Services Board on the ground that the finding should not be substantiated. 33 V.S.A. § 6906(d).

A "vulnerable adult" is defined in the regulations, in pertinent part, as follows:

As used in this chapter:

. . .

(14) "Vulnerable adult" means any person 18 years of age or older who:

. . .

(C) has been receiving personal care services for more than one month from a home health agency certified by the Vermont department of health or from a person or organization that offers, provides, or arranges for personal care; or

(D) regardless of residence or whether any type of service is received, is impaired due to brain damage, infirmities of aging or a physical, mental or developmental disability:

(i) that results in some impairment of the individual's ability to provide for his or her own care without assistance, including the provision of food, shelter, clothing, health care, supervision, or management of finances; or

- (ii) because of the disability or infirmity the individual has an impaired ability to protect himself or herself from abuse, neglect, or exploitation.

33 V.S.A. § 6902

There is no dispute that both B.B. and T.R. are vulnerable adults under the above definition. They both receive personal care services arranged through the community mental health agency and both have developmental disabilities that require supervision and assistance with daily care. The evidence is insufficient to conclude that R.H. is a person who meets this definition. Therefore, any findings by DAIL that the petitioner abused, neglected or exploited R.H. have not been substantiated and must be dismissed.

The regulations define abuse and neglect, the remaining allegations, in pertinent part, as follows:

As used in this chapter:

- (1) "Abuse" means:
 - (A) Any treatment of a vulnerable 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 pain or unnecessary suffering to a vulnerable adult.

. . .

- (E) Intentionally subjecting a vulnerable adult to behavior which should reasonably be expected to result in intimidation, fear, humiliation, degradation, agitation, disorientation, or other forms of serious emotional distress; or
- (F) Administration, or threatened administration of a drug, substance, or preparation to a vulnerable adult for a purpose other than legitimate and lawful medical or therapeutic treatment.

. . .

- (7) "Neglect" means purposeful or reckless failure or omission by a caregiver to:

- (A)(i) provide care or arrange for goods or services necessary to maintain the health or safety of a vulnerable adult, including but not limited to, food, clothing, medicine, shelter, supervision and medical services, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative, or a terminal care document . . .

. . .

- (iii) carry out a plan of care for a vulnerable adult when such failure results is or could reasonably be expected to result in physical or psychological harm or a substantial risk or death to the vulnerable adult, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative, or a terminal care document. . .

- (B) Neglect may be repeated conduct or a single incident which has resulted in or could be expected to result in physical or psychological harm, as a result of subdivisions (A)(i), (ii), or (iii) of this Subdivision (7).

The evidence shows that the petitioner failed to provide B.B. with a clean and comfortable room during the two weeks he was at his home. There can be no doubt that cleaning feces from the floor and bedclothes is necessary to maintaining the health of the vulnerable adult. In spite of the petitioner's assertion that he was not responsible for this situation, the evidence shows that he is the one who contracted to provide this care to B.B. and was ultimately responsible for the condition of the room he provided to B.B. The petitioner offered no explanation for his failure to note this condition in the two weeks that B.B. lived in his home. It must be concluded that the petitioner neglected the health needs of B.B. within the meaning of the above statute at 33 V.S.A. § 6902(7)(A)(1). DAIL was correct under the statute in substantiating a finding of neglect by the petitioner of the vulnerable adult, B.B.

The evidence also shows that the petitioner warned T.R. not to report violence he had witnessed to his caseworkers or risk repercussions. The petitioner's statements were intentional and designed to intimidate T.R., particularly in light of the violence T.R. had already witnessed between the petitioner and R.H. Those statements constitute abusive intimidation as that term is defined in the statute at 33

V.S.A. § 6902(1)(E). DAIL was correct to conclude that the petitioner had abused the vulnerable adult, T.R. within the meaning of the above statute.

Furthermore, the evidence shows that the petitioner failed to carry out a plan of care¹ requiring that T.R. drive only with supervision. Failure to carry out this plan could reasonably be expected to cause physical harm or substantial risk of death to T.R. Again, DAIL had accurate and reliable information that the petitioner neglected to carry out the plan of care for T.R. within the meaning of neglect statute at 33 V.S.A. § 6902(7)(A)(iii), cited above.

There is insufficient evidence to conclude that the petitioner threatened T.R. with the administration of a substance to give him AIDS. Therefore, it cannot be concluded that these facts pose an additional ground for abuse found at 33 V.S.A. § 6902(1)(F). However, as DAIL has proven other facts which constitute abuse and neglect of T.R., DAIL was correct to enter the petitioner's name in the abuse registry under the above statute. As DAIL's decisions with regard to both B.B. and T.R. are consistent with the

¹ "Plan of care" is specifically defined in the regulations as "includes, but is not limited to, a duly approved plan of treatment, protocol, individual care plan, rehabilitative plan, plan to address activities of daily living on similar procedure describing the care, treatment or services to be provided to address a vulnerable adult's physical, psychological or rehabilitative needs." 33 V.S.A. § 6902(8).

statute, the Board is bound to affirm the result. 33 V.S.A.
§ 3091(d), Fair Hearing Rule 17.

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