

2. At the hearing the Department introduced the testimony of a coworker of the petitioner, who allegedly witnessed the incident in question, and whose report to the employer led to the Department's investigation of the matter.

3. The coworker testified that she and the petitioner were employed as aides at the nursing home where D. resides. On September 21, 2004 the witness and the petitioner were bathing different residents in the same shower room. The witness stated that D. had soiled herself and was loudly protesting the petitioner's attempt to shower her, and that she saw the petitioner slap D. on the chin and tell her to quiet down. The witness stated that the slap was "not violent".

4. The coworker also testified that a few minutes later she heard the petitioner say to D., "I told you to shut up"; and that when the petitioner saw her nearby she said to the coworker, "I know I shouldn't have said that".

5. The petitioner's supervisor at the nursing home testified that a few minutes after D. had gotten out of the shower she observed and treated a minor cut and bruise on the back of D.'s hand.

6. The supervisor and the program director of the home testified that the petitioner had worked at the home without

incident for four and a half years and that her work with the residents had been frequently praised.

7. The petitioner testified in her own behalf at the hearing. She denied hitting D. and telling her to shut up. She admits she placed her hand on D.'s chin to get her attention in an attempt to quiet her down. She also admitted she told D. to "hush up". The petitioner stated that she first noticed D. had cut her hand after D. had been left alone for a few minutes in her wheelchair following her shower.

8. All of the witnesses who testified at the hearing, including the petitioner, appeared to be credible. Based on conflicting credible testimony, it is found that the coworker was mistaken in her observation that the petitioner "slapped" D. In light of the coworker's testimony that this contact was "not violent", it is found that the petitioner abruptly placed her hand on D.'s chin to get her attention. It cannot be found that this act was reckless or malicious.

9. It is also found that there is no evidence from which it can reasonably be concluded that the petitioner caused the cut and bruise on the back of D.'s hand. Nobody saw D. injure her hand. The witnesses agreed that D. was agitated by having been in the shower, and it is just as

likely that she hit her hand on her chair or another object during the brief time she was left sitting alone immediately afterwards.

10. The only disputed allegation that is supported by a preponderance of the evidence is that the petitioner told D., "I told you to shut up". However, there is no evidence that the petitioner was gruff, angry, or otherwise intimidating toward D. when she said it. Further, there is no evidence that this single incident caused D. any harm or emotional distress or that it was likely to place her at any risk of such harm.

ORDER

The Department's decision substantiating abuse by the petitioner is reversed.

REASONS

The Commissioner of the DAIL is required by statute to investigate reports regarding the abuse of vulnerable adults, including 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, 6911(b). Persons who are found to have committed abuse may apply to the Human Services Board pursuant to 33 V.S.A. §

6906(d) for relief on the grounds that the report in question is "unsubstantiated".

The statute which protects vulnerable adults, 33 V.S.A. § 6902, defines "abuse" as follows:

(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 harm, unnecessary pain or unnecessary suffering to a vulnerable adult;

(C) Unnecessary or unlawful confinement or unnecessary or unlawful restraint of a vulnerable adult;

(D) Any sexual activity with a vulnerable adult by a caregiver who volunteers for or is paid by a caregiving facility or program. This definition shall not apply to a consensual relationship between a vulnerable adult and a spouse, nor to a consensual relationship between a vulnerable adult and a caregiver hired, supervised, and directed by the 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.

As found above, credible evidence in this case establishes that the petitioner, while engaged in her work as an aide at a nursing home, abruptly put her hand to the chin

of a resident in a nonviolent manner and later said "I told you to shut up" to the same resident. The petitioner's conduct was isolated, and there is no evidence establishing any harm or injury to the resident in question from either of these acts, or that she was likely to have been in any way harmed by them.

Thus, it must be concluded that the petitioner's actions in this case, though probably unnecessary, inappropriate, and unprofessional, did not rise to the level of "intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain or unnecessary suffering" within the meaning of subsection (B) of the above statute. See K.G. v. Dept. of Social and Rehabilitation Services, 171 Vt. 529 (2000). It must also be concluded that a single isolated statement of "shut up" to a nursing home resident does not, per se, amount to "intimidation" or any other "serious emotional distress" to that resident as contemplated by subsection (E), above.

The Board has held repeatedly that an "inappropriate" choice for dealing with an elderly or mentally ill adult does not automatically rise to the definition of "abuse" found in the statute. See Fair Hearing Nos. 15,325, 16,822, 17,203, and 18,698. As in those cases, the Department has failed to

meet its burden of showing that the petitioner herein acted with the degree of intent, recklessness, or maliciousness necessary under the statute to find "abuse".¹ Thus the petitioner's request to reverse the substantiation must be granted.

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¹ In Fair Hearing No. 17,203 no abuse was found, albeit under a prior version of § 6902 (it was amended in 2002), even though that nursing home employee "yelled at and slapped a resident on his hand, and forcibly held a sheet over his face". Clearly, the petitioner's conduct in this case was far less egregious. It cannot be concluded that even the amended version of the above statute intended to designate such minor, isolated, and inconsequential actions as "abuse".