

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 19,886
)
Appeal of)

INTRODUCTION

The petitioner appeals a finding by the Department for Aging and Independent Living (DAIL) that she abused two elderly nursing home residents and should be placed in the abuse registry.

FINDINGS OF FACT

1. The petitioner works as a licensed nursing aid (LNA) at a nursing home.

2. On January 30, 2005, AG, the charge nurse at the nursing home, received a complaint from the daughter of DM, a patient at the home, that her mother had reported being abused the previous evening by the petitioner. DM is an eighty-six year old patient who suffers from dementia, hallucinations and paranoid schizophrenia of some forty years' standing.

3. On January 30, 2005, AG received a second complaint from another patient, TT, that she had been treated roughly by the petitioner on the previous

evening as well. TT is a ninety-one-year-old woman with a history of a fractured right femur, a gangrenous right foot and a swollen and painful left foot. The complaints were reported to DAIL which conducted an investigation and concluded that the two patients were abused by the petitioner. A Commissioner's review was held on July 12, 2005 which affirmed the prior findings of abuse. The petitioner appeals from this finding.

4. Extensive testimony was taken from all persons involved in these matters with the exception of DM who was not called due to her inability to recount the incidents complained of. The testimony of the witnesses and documents submitted can be summarized as follows:

Evidence Relating to TT

- a. The petitioner herself testified that she was on duty on the evening of July 29 and had attended to TT. Her duty with regard to TT was transferring her from her wheelchair to a bed. The petitioner says she checked the profile on TT to see how she was to be transferred and read that she was a two person transfer or she could be transferred by one person through the use of a slide board. TT advised the petitioner before the transfer that her left ankle was hurting and that she needed to be especially careful. She complained that "no one does anything about it [the pain]". The petitioner says that TT successfully got herself into the bed using the slide board and that the petitioner then carefully cradled her feet and legs and turned them into the bed.

She then called another staff member to help her reposition TT in bed. She says that the petitioner made no complaints of pain at that time.

- b. DP, another LPN working that night in the hall opposite TT's room, was asked by the petitioner to help her reposition TT directly after the transfer. He said that he neither heard nor saw anything inappropriate, that TT did not complain of pain or an injury to him and that she was able to engage in small talk with him for the half a minute or so that he was in the room with DM. He noted that the petitioner herself was pleasant.
- c. Later in the evening of January 29, 2005, TT called DA, another nursing assistant, and asked him for a Tylenol for pain during the night. He said that she was crying but that she always cried when she was in pain from her leg which was frequently. TT then told him that the petitioner had ignored her requests to be cautious with her left leg and had "ripped her clothes from her", "whipped her into bed" and that she had picked up her legs and swung them into the bed and "kept pushing and pulling her from one side to the other." TT added to him that she did not think anything was purposely done but that it hurt her. He said that both of them thought it was a minor thing but DA reported her allegations to the nurse in charge the next day as procedures required.
- d. JH, the floor nurse that night, filed a report saying that she had received no reports from the petitioner or anyone else that there had been difficulty with TT's care the evening of January 29. She reported that TT had slept comfortably without unusual pain that night. She said that TT got routine medications for pain the evening before and had not asked for extra medication for "breakthrough" pain. The next day she testified that she dressed TT's right great toe. She noted at that time that her left ankle was swollen which she described

as a chronic problem for her. She noticed nothing unusual about the condition. She was surprised that TT made a complaint of injury the next day because she had observed no injury during her examination. She described the petitioner as a person who could be difficult and had been known to exaggerate problems with staff. In support of this assertion, she referred to a written nursing report dated February 27, some four weeks after the alleged incident, stating that TT had complained that no one answered her call bell (asking for a blanket) for two hours when it had actually been five to ten minutes. The report also described TT as exhibiting inappropriate and abusive behavior to responding staff.

- e. AG, the nurse who took the official complaint from TT on January 30, said that TT asked for her during her January 30 shift and told her that the petitioner had lost her balance as she was placing her into a Heuer lift (not the same as a slant board), did not really have a hold on her and should have had a second person assisting her. She reported to AG that her "leg was broken" but AG observed no bruising or other injury to her foot. She talked to JH the nurse on duty during that shift who told her that she had seen no injury but would monitor the situation. AG noted that TT's foot was swollen but said that it was always swollen from edema and that the swelling could cause pain. AG said that the petitioner constantly complained of pain in her left foot and leg and that she was not surprised by her complaint that day. However, she reported the allegation because she had alleged that she was treated roughly.
- f. TT reported to the Director of Nursing, AN, on January 31, 2005, that the petitioner had not used a slide board but rather had lifted her by her upper torso under the arms from the wheelchair and placed her directly into her bed. AN said that she was not aware of TT's

exact transfer requirements but could not say that the methodology used by the petitioner was in itself incorrect.

- g. TT's son reported that his mother came to the facility in July 2003 which a fractured right femur which has since healed although her right leg is gangrenous. Because she can no longer pivot on her legs, she uses a slide board to get into bed which is managed by one or two persons. Her left leg which is in better condition is plagued by peripheral vascular disease and edema. He was called by the facility with regard to the incident of January 29 and, at their suggestion, took his mother to the hospital for an X-ray. He felt her left ankle appeared more swollen than usual and that she was in pain. She told him that she had been dropped by a helper. He said that his mother hated being in the facility because of her loss of independence. He described her as now being unable to bear weight on her foot and in need of pain killers but did not claim that condition was caused by the alleged incident. He said she is gradually losing mobility in all limbs.
- h. An X-ray was taken of TT's left ankle to determine if there had been a fracture. The impression of the radiologist was that the petitioner had diffuse osteoporosis, degenerative changes resulting in joint space narrowing, swelling of the soft tissues in the ankle joint due to edema, and a possible hairline fracture of the distal fibula. The possible hairline fracture was linked with the osteoporosis. No opinion was offered as to whether the ankle had been twisted.
- i. During her own testimony at the hearing TT said that the petitioner was turning her legs onto the bed (the maneuver used in a slide board transfer) and had accidentally turned her ankle. She repeated that the petitioner had not twisted her leg on purpose but it had hurt

all the same. She did not renew her allegations of purposeful and reckless behavior. She said that she could not walk on that leg now.

Evidence Relating to DM

- a. With regard to DM, the petitioner says she was asked by the charge nurse to take DM to her room after she was observed screaming in the hallways shortly before 7 p.m. The petitioner says she often volunteered to help with this difficult patient because no one else wanted to handle her. The petitioner seemed to be suffering a psychotic episode and had not received her medications for the evening. The petitioner's task was to attempt to calm her down and to get her into bed until her medications could be dispensed, which usually occurred about 9:30 p.m., her usual bedtime. The petitioner says that DM was screaming that she wanted to go and see her husband. DM's husband is deceased and DM believed that her husband was her physician. The petitioner says that she attempted to calm the petitioner down by going along with her attempts to pack her clothes for a trip to see her "husband" and speaking calmly to her. She made several suggestions to the petitioner about washing her or watching TV to try to redirect her from her anguish. She says DM was finally comforted and agreed to go to bed, so long as the clothes she had packed for her visit with her "husband" were kept in her view. She says she did not treat DM roughly when getting her into bed and DM never complained to her that she was hurt or felt she was being roughly treated in any way.
- b. SW, an LNA who was working across the hall from DM's room on the night in question, testified that she heard DM screaming and heard the petitioner speaking to her in a low voice. He heard nothing unusual that night. He said that staff often has to calm DM down

because of agitated episodes and that it was not unusual to try to put her to bed early to calm the episodes until her medication came.

- c. JH, the charge nurse on the evening of January 29, 2005 came into DM's room sometime after 7 p.m. to administer medications to DM. At that time DM was agitated and screaming for her "husband". She gave her a dose of Haldol which did not calm her and gave her another dose of Ativan at 2:30 a.m. which soothed her agitation. DM said nothing to her that night about having been abused by the petitioner in any way. She said that it was her experience that the petitioner was disoriented on a daily basis. She said that their method of dealing with DM's agitation was to try to redirect and calm her and then to medicate her if that was not effective.
- d. AG was the nurse on the following shift who took the complaint from DM. She observed that DM has "extreme" cognitive problems which caused her to be disoriented on a daily basis but noted that she did not usually complain about pain.
- e. DM's daughter, CL, testified that she found her mother in an agitated state during a visit on January 30, 2005, and that she had complained to her that "they were rough with her the night before" and that her arm and chest had been hurt. CL could not see any injury but was concerned and reported her mother's statements to the staff. She said that her mother told her that her left hip and left chest hurt and that a girl dressed in white shorts and pink shirt treated her roughly while washing her and pushed her into bed. CL felt her mother had been clear about an incident occurring the prior night and it was unusual for her to complain of pain to her. CL agreed that her mother is often disoriented, is often agitated due to her mental condition, is frequently mad at and

complains about staff and that two days before this report she had accused staff members of poisoning her. She also agreed that she was currently suffering from delusions, including her belief that her physician was actually her husband and that she had recently given birth to two babies.

5. DAIL appointed a nurse surveyor to investigate the above complaints. The surveyor talked with all the above witnesses and looked at the nursing notes and reports of the incident on file at the nursing home. She prepared a report in which she concluded that DM and TT had been abused largely because she believed the petitioner had failed to follow the plan of care for each patient. She admitted that the report did not mention DM's dementia, the reports written by JH the floor nurse or the radiology report.

6. The Commissioner heard from the petitioner and reviewed the surveyor's findings and concluded in a written document dated July 29, 2005 that the petitioner had failed to use the slide board on TT as set forth in the case plan which showed a reckless disregard for her and which placed her life in jeopardy. The Commissioner also concluded that the petitioner had partaken in a rough struggle with the petitioner to put her bed early in the evening before her preferred bedtime of 9:30 p.m.

and had thereby subjected her to intimidation, fear, humiliation and degradation and had shown a reckless disregard for her health and placed her health in jeopardy.

7. It is found that the testimony of all the nursing home personnel, including AG, DP, DA, JH, SW, and AN is entirely credible and consistent.

The testimony of CL, DM's daughter is found credible but her testimony is insufficient as a matter of law to prove that the events reported to her occurred.

Likewise, the testimony of DM's son about his actions following the report are found to be credible although his observation that his mother's ankles seemed more swollen than usual is not found as fact since it is contrary to the findings of all the health professionals who examined her in the days following January 29, 2005 that there was no extraordinary swelling.

8. There is insufficient evidence upon which to conclude that the petitioner physically injured either TT or DM. There was no confirmation in the record that TT's ankle was twisted or that she was ever treated for a twisted ankle. On the contrary, the X-ray report and observations of the nursing staff indicated that her

swollen ankles were related to edema. No fracture of any kind could be confirmed and any hairline fracture that might possibly exist was linked to severe osteoarthritis or degenerative changes in TT's left foot. There was no indication that any of TT's foot problems were related to a recent trauma. No evidence of any injury was ever documented for DM.

9. Although TT initially claimed that she was treated roughly by the petitioner, her report of the details of the rough treatment she received was reported in radically different versions to three staff members within a forty-eight hours period (dropped from a Heuer lift to the shift nurse, legs twisted onto the bed from a slide board to a nursing aid, and lifted by the underarms from the wheelchair on to the bed to the nursing director). Her testimony at the hearing offered a fourth version of events which described the petitioner as accidentally causing injury to her without any allegations of recklessness or lack of care. Given this inconsistency in her testimony coupled with credible testimony of JH that near the same time she had exaggerated staff behavior towards her on at least one occasion and had unjustly abused staff, it cannot be

found that TT's testimony accurately portrayed what occurred on the evening of January 29. There is no doubt that the petitioner was experiencing pain in her feet, most likely due to edema, and may have honestly believed that the pain occurred as the result of her transfer. However, that belief does not translate into a finding that the petitioner actually mistreated her during the transfer.

10. The petitioner's version of events which was supported by the credible observations of other staff members and TT's son (the staff member nearby heard nothing unusual coming from the room and did not observe the petitioner in distress during repositioning; the petitioner received only usual pain treatment during the night and did not ask for special breakthrough medications; the petitioner was using the transfer method prescribed for TT) is found to be credible with regard to her treatment of TT.

11. DM offered no direct testimony of what happened to her and was not available for cross-examination at the hearing. The only report of what happened to her was relayed through the testimony of her daughter which testimony is inadmissible hearsay to

prove the truth of the treatment DM says she received.¹
It cannot therefore be fairly concluded that events unfolded in the way DM reported to her daughter.

12. Again, the petitioner's version of events with regard to DM is found to be credible because that version is supported by the testimony of other staff members, namely: that the petitioner was overheard speaking in a low voice to the petitioner, that DM was observed by others to be agitated and delusional about a trip she was to take with her "husband" before being administered to by the petitioner, that the procedure the petitioner followed was that prescribed by the nursing staff, and that no injuries could be found consistent with DM's complaint.

13. It cannot be found based upon the above evidence that the petitioner failed to carry out the plan of care for either DM or TT.

¹ The Board is required to use Vermont Rule of Evidence 804a in hearings involving mentally disabled adults. That rule does not allow hearsay statements to prove the truth of the allegations unless the mentally disabled adult is made available to testify at the hearing. DAIL did not make the disabled adult available at the hearing and admits that she has no memory of the event. See In re C.M., 168 Vt. 389 (1998).

ORDER

The decision of DAIL substantiating abuse and neglect of DM and TT by the petitioner is reversed.

REASONS

The Commissioner of the Department of Aging and Independent Living (DAIL) is required by statute to investigate reports regarding the abuse of elderly persons and to keep those reports which 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 Department to prevent such a finding from being entered in the registry as unfounded. 33 V.S.A. § 6911(d). A denial of this application may be appealed to the Human Services Board pursuant to 3 V.S.A. § 3091(a).

DAIL placed the petitioner's name in the registry because she was found to have abused two vulnerable adults and to have neglected them by failing to carry out their plan of care. As found above, there is no credible evidence that the petitioner in this matter engaged in the activity described by the complainants TT

and DM or that she failed to carry out the plan of care for either vulnerable adult. The fact that two complaints were received in one night is cause for concern and investigation but does not prove that either event occurred. No argument was made by DAIL that the petitioner's version of the events, which was found to be entirely credible, constitutes abuse or neglect as those terms are defined in the statute at 33 V.S.A. § 6902.² As DAIL has failed to meet its burden of showing

² (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.

. . .

(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, as defined in subchapter 2 of chapter 111 of Title 18;

(ii) make a reasonable effort, in accordance with the authority granted the caregiver, to protect a vulnerable adult from abuse, neglect or exploitation by others;

(iii) carry out a plan of care for a vulnerable adult when such failure results in or could reasonably be expected to result in physical or psychological harm or a substantial risk of 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, as defined in subchapter 2 of chapter 111 of Title 18; or

(iv) report significant changes in the health status of a vulnerable adult to a physician, nurse, or immediate supervisor, when the caregiver is employed by an organization that offers, provides or arranges for personal care.

(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).

by a preponderance of the evidence that abuse or neglect, as defined in the regulation, occurred, the Board must reverse the decision.

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