STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. M-05/19-339
	)	
Appeal of	)	
	)	

INTRODUCTION

Petitioner appeals a substantiation determination by the Department of Disabilities, Aging and Independent Living ("DAIL" or "Department"). The issue is whether a preponderance of evidence supports a conclusion that petitioner neglected a vulnerable adult, under Title 33 of Vermont law. The appeal process included numerous status conferences, three days of hearings (held on September 19, 2019, October 18, 2019 and October 25, 2019), along with oral argument and written briefing by the parties, with the record closing as of January 10, 2020.[1]

FINDINGS OF FACT

1. Petitioner was a paid home provider and community support worker who, from the summer of 2017 through September 21, 2018, provided care and residential home services to

[1] This matter was heard contemporaneously with another appeal involving the same petitioner, as a matter of judicial economy and for the convenience of the parties and witnesses. However, separate decisions have been rendered for each appeal.

D.P., an adult woman with intellectual and psychiatric disabilities.[2] There is no dispute, and the parties agree, that D.P. is a vulnerable adult as defined by 33 V.S.A. § 6902(14).

2. D.P. resided in petitioner's home during the period stated in the preceding paragraph. D.P.'s disability causes her to experience auditory hallucinations as well as anxiety and depression. D.P. is incapable of meeting all her own needs without assistance and receives services and supports that are provided through Washington County Mental Health (WCMH).

3. The services required to meet D.P.'s needs were outlined in a care plan also known as an Individual Support Agreement (ISA) developed by WCMH.

4. Petitioner signed contracts with WCMH, running from July 1, 2017 to June 30, 2018 and July 1, 2018 to June 30, 2019, to serve as D.P.'s caregiver and received financial remuneration in exchange for implementing the plan of care as well as providing room and board, and, in essence delivering 24-hour care to D.P. The parties agree and there is no

[2] The record in this matter indicates that petitioner continued to reside with and provide services to D.P. after this date, in a different residential location, but that circumstance is not material to the matter under review herein.

dispute that petitioner met the definition of caregiver as defined by 33 V.S.A. § 6902(2).

5. The ISA that governed and described the level of care necessary to keep D.P. safe poses the following questions: "How much of your day and night can you be left alone? Under what circumstances?": The response states" [D.P.] should not be left alone at all during the day due to previous behaviors that have (*sic*) lead into safety concerns." However, the plan immediately follows that directive with modifying language to make clear that "[D.P.] does not needs eye-one(*sic*) supervision 24/7, but should always have someone home with her at all times." In addition, the plan states: "[D.P.] does not have any restrictions of her daily activities at this time" and notes "[D.P.] is able to communicate verbally. Sometimes [D.P] has a hard time finding words, but is able to make her needs and wants known." Finally, the plan of care noted that D.P. "needs coaching and reminding to complete household chores and personal care tasks such as bathing, washing her ha1r taking her medications..." but does not state, imply or infer that D.P. can not take the medications on her own. By its terms, the obligation set forth in the plan of care for the caregiver in this instance is only to coach and remind D.P.

to accomplish these tasks. This gives rise to an inference that a degree of autonomy is expected on the part of D.P. to take these actions to completion once given reminders or coaching.

6. Petitioner, in addition to her caregiving obligations toward D.P., worked full time at a home for the developmentally disabled. This employment, though not the number of hours or shifts worked, was known to the case manager at WCMH and was not viewed as interfering with the provision of services to D.P., nor was it in any way prohibited under the contract between WCMH and petitioner.

7. Petitioner on occasion brought D.P. with her to work. Testimony adduced at hearing confirmed that this was acceptable to petitioner's employer and that D.P. enjoyed being at petitioner's workplace.

8. That petitioner cared deeply for D.P., was viewed as fully satisfying her obligations under the contract with WCMH and was well liked and trusted by D.P.'s family, was uncontroverted. This appears to have remained the case even after DAIL's decision to substantiate petitioner and the institution of these appeal proceedings.

9. Uncontested testimony at hearing established that D.P. enjoyed her relationship and living situation with

petitioner and generally flourished during the time that petitioner served as her caretaker.

10. Petitioner shared her home with her husband L.G., who was a member of the household during the time that D.P. lived there with petitioner.

11. Prior to the date that D.P. began residing in petitioner's home, L.G., petitioner's husband, was diagnosed with dementia. While petitioner may have been in denial about the diagnosis, or honestly did not recall the date when she first learned of it, it was her own concerns about her husband's memory and his changes in behavior that brought the issue to the attention of his health care providers. It is undisputed that petitioner accompanied her husband to several medical appointments where the matter of his memory deficits in particular was discussed. Provider notes from these appointments, which began in April 2017 regularly note discussions and diagnostic testing for dementia, but petitioner was not present for many of these appointments. By May or June of 2018, the records strongly infer that petitioner was aware of the diagnosis by that point in time. In August of 2018 L.G.'s license to operate a motor vehicle was revoked based on a statement from his medical provider that L.G. had dementia.

12. Evidence was presented at hearing regarding L.G.'s abilities and behavior that DAIL asserts were consistent with memory loss and cognitive decline. What remains unclear and uncertain, however, despite the confirmed dementia diagnosis, was whether and in what way the dementia manifested itself in terms of L.G.'s behavior and functioning in the home, during the time that D.P. was living there and what impact if any, L.G.'s condition may have had on D.P.'s health and safety.

13. The home provider contract between petitioner and WCMH required petitioner to "notify the Agency of any event which may materially affect the shared living environment, including major illness of the Contractor or any resident of the developmental home", but petitioner did not report her husband's dementia diagnosis to WCMH. On this record it was not clear how, when or even if, the manifestations of L.G.'s dementia 'materially affected the shared living environment' in petitioner's home.

14. The bulk of the evidence about L.G.'s behavior in the home came mainly from three witnesses: petitioner herself, and L.G.'s two daughters from a prior marriage. A limited amount of testimony came from D.P.'s WCMH case manager who conducted several home visits at the residence, during which L.G. was present and from D.P.'s sister, who had

very occasionally observed L.G. in petitioner's home during visits.

15. The WCMH case manager testified that L.G. was a quiet, cordial man of few words and indicated that she was surprised to later learn that he had been diagnosed with dementia. She was aware that D.P. stayed in the home in the company of only L.G. and based on what she had observed of L.G. did not have concerns regarding D.P., though during hearing she testified that if she had been aware of the specific situation with respect to the diagnosis, she would have wanted to evaluate whether any change was warranted.

16. Testimony established that L.G.'s daughters were approximately the same age as petitioner, and that petitioner was more than twenty years younger than her husband L.G. One of petitioner's daughters lived across the street from the family home occupied by petitioner and L.G. and the other daughter visited regularly and ultimately moved there in August of 2018.

17. L.G.'s daughters informed the APS investigator and later testified at hearing about specific types of memory loss experienced by L.G. that they believed were consistent with his diagnosis of dementia. These included the loss of the ability to operate certain appliances and equipment such

as an air compressor, an electrical breaker, a faucet, a television remote control, an electric can opener, and eventually the loss of the ability to drive a car. While testimony was adduced that L.G. was unable to use one particular telephone, the same witness indicated that in response, a different telephone was purchased and that this telephone was easier to use. The logical inference to be drawn from this last information is that L.G. was able to use the telephone.

18. It is abundantly clear from testimony that the relationship between petitioner and L.G.'s daughters, though cordial early on in petitioner's twenty-three-year marriage to L.G., had become quarrelsome and extremely combative by the time of the events described herein. No party disputed that the relationships had become very difficult and the APS investigator testified that he was aware of this circumstance from the outset. At hearing, it was also evident that the relationships remained very strained and contentious even following the death of L.G., which occurred in August of 2019, the month prior to the commencement of the hearing in this matter.

19. There is no dispute that on at least three occasions, D.P. remained in the home with only L.G., while

petitioner left the premises either to go to work, or to run errands or both. No testimony was presented about when during the time D.P. lived with petitioner, D.P. stayed home in the company of only L.G. to go to work and thus this could have been any time between April of 2017 and September of 2018.

20. Other than petitioner's admission that D.P. was home with her husband for twenty minutes while she ran an errand, approximately two days before she moved out on September 21, 2018, there was no evidence presented as to the dates, or duration of these occasions. Nor was any evidence adduced that could support the conclusion that leaving D.P. home with L.G. posed a health or safety risk to D.P.

21. There is no dispute that on regular basis, D.P. spent time, including overnights and weekends at the homes of her sister and her elderly parents. At one point during the period at issue in these proceedings, D.P. was hospitalized for several days following a weekend spent at her parents. No information was provided as to when this hospitalization had taken place.

22. When D.P. would leave for overnight family visits, petitioner would pack a bag for her and include all medications taken regularly by D.P. Petitioner testified

that when D.P. returned from these excursions, on occasion she discovered medications were found unopened in her overnight bag. While D.P. could take her own medication, she did need reminders. Upon being made aware of this situation, D.P.'s case manager at WCMH, who held monthly meetings with petitioner and D.P.'s family to discuss the plan of care, proposed devising strategies so that this did not recur.

23. During the investigation of this case, one of petitioner's daughters-in-law provided photographs to the APS investigator of unopened medication blister packs, that she reported to have found in petitioner's home. The medications were identified by their labels as having been prescribed for D.P., on dates during the time D.P. lived in petitioner's home. From the photographs admitted into evidence, it appears that there were a total of 8 doses of unopened medication for D.P., four of which were dated for February 6th and 7th, one of which was dated March 21st, another was dated March 26th and the last of which was dated September 18th, all presumably for 2018.

24. No evidence was presented on the nature of the medications themselves, meaning what the specific medications were, or what they were prescribed for, by whom or whether missing the dosages identified in the photos, in the amounts

and on the dates in question, would have had a deleterious effect on D.P.'s health. Nor was any explanation provided as to why the medications had not been taken on the dates and times identified on the blister pack or where D.P. had been residing on those dates.

25. During the investigation D.P. was interviewed and asked about her relationship with L.G., during which she is reported to have made contradictory statements about L.G., saying on the one hand that she thought he was nice, but on the other that that he had yelled at petitioner and that she did not like being home with only him. Testimony from petitioner noted that D.P. had been observed to have a friendly relationship with L.G, watching sports games on television with him and joking with him. However, D.P. was also reported to have retreated to her bedroom when she sought to avoid interactions with others, including L.G.

26. No testimony was presented that demonstrated that L.G. was a danger to himself or others during the time that D.P. resided in the home with him and petitioner. In fact, all the testimony and evidence about L.G. and his condition, were focused on his memory loss and cognitive decline and not behaviors that he exhibited which reasonably could have been

expected to pose a health and safety risk to D.P. or to result in her experiencing physical or psychological harm.

ORDER

The Department's decision is reversed.

REASONS

The Department of Disabilities, Aging and Independent Living investigates allegations of abuse, neglect and exploitation concerning vulnerable adults. *See* 33 V.S.A. §§ 6901, *et. seq.* Names of individuals substantiated for abuse, neglect or exploitation are placed on a registry maintained by DAIL which may be disclosed to potential employers or volunteer organizations serving vulnerable adults, *see* 33 V.S.A. § 6911(b), potentially affecting an individual's employment, livelihood, and associations. Appeals from a substantiation finding are reviewed by the Board de novo and DAIL has the burden of establishing the substantiation by a preponderance of the evidence.

There is no dispute that D.P. was a vulnerable adult - nor can there be any dispute that petitioner met the definition of a "caregiver" for D.P. *See* 33 V.S.A. § 6902(2). The sole issue in this appeal then, is whether

petitioner's actions and conduct meet the definition of neglect under the statute.

"Neglect" is defined, in pertinent part, as:

> (7)(A) purposeful or reckless failure or omission by a caregiver to:
>
> (i) provide care or arrange for goods or services necessary to maintain the health or safety of a vulnerable adult, including 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 an advance directive, as defined in 18 V.S.A. § 9701;
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> (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 advance directive, as defined in 18 V.S.A. § 9701; 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).

33 V.S.A. § 6902(7).

DAIL's burden on appeal is to prove that petitioner's actions while she served as caregiver to D.P. meet this definition. They have not satisfied this burden. Put differently, the Department did not demonstrate that petitioner failed: either purposefully, recklessly or by omission; to "provide care or arrange for goods or services necessary to maintain the health and safety" of D.P., or that petitioner failed to carry out a plan of care for D.P. in a manner that "could reasonably be expected to result in physical or psychological harm or a substantial risk of death" to D.P.

DAIL's conclusion that petitioner neglected D.P. is based on two specific circumstances. The first of these is that petitioner left D.P. at home with her husband L.G., after he had been diagnosed with dementia. The second circumstance is that during the time that D.P. lived with petitioner, D.P. did not take some of her prescribed medication.

The first circumstance presents the more complex situation. At hearing DAIL adduced compelling evidence that prior to becoming the caregiver for D.P., petitioner's husband had been diagnosed with dementia, and that this was information which petitioner knew or should have known based

on her presence and participation during numerous medical visits with L.G. when which L.G.'s memory lapses and behavioral changes were discussed and evaluated. As evidence demonstrated that petitioner herself reported and raised concerns about L.G.'s memory lapses and later behavioral issues at the medical appointments it is clear that during this time, petitioner was aware of L.G.'s memory deficiencies and cognitive decline. However, the evidence does not demonstrate that petitioner was specifically aware of the diagnosis until May or June of 2018.

It is not necessary for the purposes of reaching a decision in this case to determine whether L.G. was a vulnerable adult or whether petitioner was his caregiver pursuant to the legal definitions under Vermont law.

The key inquiry then is whether, by leaving D.P. home, in only the company of L.G., did petitioner neglect D. P. either purposefully, recklessly or by omission, by failing to provide care for necessary to maintain D.P.'s safety as defined in 33 V.S.A. § 6902(7)(A)(i), or in the alternative did petitioner fail to carry out a plan of care for D.P. in a way that could reasonably have been expected to result in physical or psychological harm or a risk of death as defined in 33 V.S.A. § 6902(7)(A)(iii)?

No testimony was presented that demonstrated that L.G. was a danger to himself or others during the time that D.P. resided in the home with him and petitioner. In fact, all the testimony and evidence about L.G. and his condition, were focused on his memory loss and cognitive decline. In addition, the testimony about L.G.'s behavior focused on specific instances that while consistent with cognitive decline, such as putting clothing on inside out, or forgetting how to use a remote control for a television, were not necessarily indicative of dementia. Such is the nature of the malady.

Critically important however is the fact that the testimony did not specifically describe the manner in which L.G.'s condition or behaviors did or could have had an impact on the safety or wellbeing of D.P. It is common knowledge that dementia can be a progressive disease, but also that its presentation in an individual is varied. What is missing here is evidence that due to L.G.'s condition, in leaving D.P. in the home alone with him, petitioner had compromised D.P.'s health and safety or that leaving D.P. home with L.G. could reasonably been expected to cause physical or psychological harm to D.P.

There was no testimony as to specifically when, during D.P.'s occupancy of petitioner's home, which lasted from April of 2017 to September of 2018, D.P. remained at the home with L.G. while petitioner worked. Nor were details provided as to how many times this happened, the duration of these instances, or what L.G.'s condition was during these occasions. Testimony was generally inconclusive even as to when the specific instances of memory loss and cognitive inability occurred, but it appears that L.G.'s memory and cognition deteriorated over time. There is also no evidence that any harm of any kind was experienced by D.P. as a result of these incidents. Indeed, there was no evidence that there had been any interactions between L.G. and D.P. on these occasions.

For example, the testimony did not establish when or how often L.G. could not use an air compressor, or operate the television, or cut up vegetables for a favorite sauce. Nor – more importantly - were these deficiencies linked to whether D.P.'s health and safety were at risk when only L.G. was present.

The only testimony regarding petitioner leaving D.P. in the home with L.G. that had a temporal reference came from petitioner herself, who indicated that she had left D.P. at

home with L.G. when she ran a twenty-minute errand two days before she ultimately left the home permanently on September 21, 2018.

The inquiry thus narrows to the following: Was leaving D.P. in the company of L.G. for uncertain periods of time on uncertain occasions or for twenty minutes in September of 2018 a purposeful or reckless failure to provide care necessary to maintain D.P.'s health or safety?

The answer to that question turns then on specifically what care was in fact necessary to maintain D.P.'s health and safety. It is logical therefore to turn to the language of D.P.'s plan of care for guidance as to both what care was necessary for D.P.'s health and safety as well as whether this circumstance may have constituted a failure to carry out the plan of care in a manner that could reasonably be expected to result in physical or psychological harm or a substantial risk of death. The plan specified that there needed to be someone in the home at all times with D.P. but significantly did not require "eyes-on" at all times. In other words, the plan of care contemplated D.P. spending time alone, unobserved, and put no restrictions on the length of time it was permissible for her to be outside the presence of

others. The plan also made clear that D.P. could communicate her needs.

The plan of care for D.P. did not require her to be observed at all times, and only required that she not be alone. D.P. was never left alone in the home. While petitioner's decision to leave D.P. at home with a person eventually known to be suffering from dementia certainly poses concerns, under the circumstances presented here the decision was not shown to pose health or safety concerns and could not have reasonably been expected to result in physical or psychological harm, or a substantial risk of death. It was DAIL's burden of proof to show that petitioner's action, in leaving D.P. at home with L.G. was a failure to provide care necessary to maintain D.P.'s health and safety, or that doing so could have reasonably been expected to result in physical or psychological harm or a substantial risk of death. They have not done so.

DAIL has also not met its burden of proof in demonstrating that the fact of certain missed dosages of D.P.'s medication constitutes neglect by the petitioner. As noted above there was no testimony as to what specific medications had been prescribed or when, or what the impact of missing those medications might have been. Furthermore,

there was testimony indicating that even when petitioner dutifully packed D.P.'s medications with her when she was not with petitioner overnight, that certain dosages were missed.

It is not possible to know whether these missed doses of medication occurred while D.P. was out of the home. No evidence of date correlations was provided to demonstrate that the missed dosages occurred when D.P. was in the home, nor was testimony elicited to show that missing the specific medications in the dosage amounts would have reasonably been expected to result in physical or psychological harm or to pose a substantial risk of death to D.P. It is also clear that petitioner's obligations under the plan of care were to give D.P. coaching and reminders about taking her medication, but not to actually control all aspects of medication management. Ultimately, the Department did not present evidence sufficient to demonstrate that petitioner was responsible for the missed medications, or that the missed medications presented a health and safety risk or cause physical or psychological harm to D.P.

The Department has failed to meet its burden of proof to show that the actions of petitioner here meet the definition of neglect in 33 V.S.A. § 6902(7). As such the decision lacks an evidentiary basis and is therefore inconsistent with

the applicable rules and statutes and must be reversed by the Board. *See* 3 V.S.A. § 3091(d); Fair Hearing Rule No. 1000.4D.

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