Note: Decisions of a three-justice panel are not to be considered as precedent before any tribunal.

ENTRY ORDER

SUPREME COURT DOCKET NO. 2007-134

MAY TERM, 2008

In re Beverly Richardson	}	APPEALED FROM:
	}	
	}	
	}	Human Services Board
	}	
	}	
	}	DOCKET NO. FH # 18,319

In the above-entitled cause, the Clerk will enter:

Petitioner appeals from a Human Services Board decision, concluding that she neglected a vulnerable adult residing in her residential care home. On appeal, petitioner claims that the Board's findings of neglect are not supported by the evidence. We disagree and affirm.

The Board found the following facts. At the time of the alleged abuse, petitioner operated a Level IV residential care home. The allegations arose from incidents in December 2002 involving one of her residents, J.M. At 2:46 a.m. on December 3, 2002, a resident at the home called for emergency assistance, because J.M. was having difficulty breathing. The Burlington Fire Department responded to the call, and at 2:51 a.m., emergency vehicles arrived at the residence with their lights flashing. Four emergency personnel responded to the call, including Assistant Fire Marshall T. Middleton, who is an emergency medical technician and an R.N. Middleton's primary responsibility at the scene was to care for the patient. The other resident, who had made the 911 call, was on the curb waiting and took emergency personnel into J.M.'s bedroom. J.M. was in bed and unable to sit up. He was short of breath, wheezing, and appeared to be hyperventilating. His rate of respiration was twenty-eight breaths per minute, and his pulse was ninety-six per minute. His neck muscles and veins were also swollen. J.M. told Middleton that he had been short of breath all day and that he stayed in his room all day without being given anything to eat. Middleton testified that swollen neck muscles are a sign of strained breathing and that, based on his experience, J.M. had been ill the previous day.

Middleton attempted to obtain information from J.M. about his medical history and current medications, but J.M. was so short of breath he could answer questions only one word at a time. Middleton did not get any information from J.M. and did not find any information in J.M.'s room. The emergency crew was also unable to locate a staff member to assist in providing such information. The emergency crew used a chair to transport J.M. to the first floor. They then transferred him to a stretcher. They left the residence at 3:06 a.m. and transported

J.M. to the hospital. The vehicles had their lights on during the entire time they were at the residence, and Middleton testified that they used their sirens when they departed. Middleton made a report to Adult Protective Services, based on his concerns that staff at the residential care facility did not notice that J.M. was have breathing difficulties and that staff were not available during the emergency call.

J.M. was discharged from the hospital on December 7, 2002. He was diagnosed with congestive heart failure. On release, he was given an order for physical therapy and five new prescriptions. One of J.M.'s prescriptions was filled on December 17, but the others were never filled. On December 9, 2002, petitioner took J.M. to the emergency room, because J.M. was again having trouble breathing and had not been given any medication. The Visiting Nurse Association (VNA) called petitioner on December 9 to arrange for J.M.'s physical therapy sessions. Petitioner agreed to contact the VNA upon J.M.'s return from the hospital. Even though J.M. returned from the hospital the same day, petitioner did not contact the VNA, and J.M. never received physical therapy.

Adult Protective Services undertook an investigation based on Middleton's report. The investigator, a nurse surveyor, interviewed J.M., petitioner, the resident who called 911, J.M.'s doctor, the VNA nurse, J.M.'s pharmacist, and petitioner's husband. During the investigation, petitioner provided several accounts of her whereabouts on the nights of December 2-3. Petitioner said she was asleep, did not hear anyone knocking, was in the shower, was getting clothes from an adjoining house or may have been grocery shopping. Petitioner also stated that she had last seen J.M. at 2:30 a.m. on December 3, when he was in his bed sleeping. J.M. reported to the investigator that his heart was pounding and that he tried to get to petitioner's room, but there was a bar on the door and no one responded. The other resident also told the investigator that he tried to locate petitioner and knocked on petitioner's door, but that no one answered. The investigator determined from petitioner's pharmacist that J.M. never filed three of his new prescriptions. She also confirmed from the VNA that J.M. did not receive any physical therapy. In addition, the investigator noted that, when she was at the residential care home on December 18, 2002, petitioner was summoned to help get J.M. out of the bathtub, because he was too weak to get out by himself.

The investigator recommended substantiation of neglect for failing to assure that: (1) J.M. obtained his new prescriptions; (2) J.M. received physical therapy; (3) J.M.'s medications were documented; (4) sufficient staff was present to provide appropriate care in an emergency; (5) and J.M.'s plan of care included nursing oversight. The Commissioner added failure to intervene during the emergency call to the list.

The Department of Aging and Independent Living (DAIL) substantiated the neglect charges, and petitioner requested a fair hearing. The Board held a hearing on October 23, 2006. At the hearing, petitioner testified on her own behalf. She stated that she brought J.M. breakfast on December 2 and offered J.M. lunch and dinner, but that he did not accept. She also stated that she last saw J.M. at 9:00 p.m. that evening and that he did not appear to be having any breathing difficulties. As to J.M.'s prescriptions, petitioner testified that she did not handle prescriptions, and she thought they had been called in to the pharmacy before J.M. left the hospital. Regarding J.M.'s physical therapy, petitioner testified that she did contact the VNA about J.M.'s physical therapy and was told that she would need a new order for the therapy, because J.M. had been

readmitted to the hospital. She also explained that the reason J.M. could not get out of the bath on December 18 was not because he was too weak, but simply because he had not put the bath mat down and the bath was soapy and slippery.

The Board affirmed the Department's decision and determined that petitioner neglected a vulnerable resident in her residential care home by failing to be available to him during a medical crisis, by failing to obtain necessary medication for him, and by failing to ensure that he received necessary physical therapy following his discharge from the hospital. Petitioner appeals.

On appeal, petitioner claims that the Board's findings are not supported by the evidence. In reviewing a decision by the Board, we will set aside findings that are clearly erroneous, but "where the record contains any credible evidence . . . fairly and reasonably [to] support the findings, the [B]oard's decision will stand." Hall v. Dep't of Soc. Welfare, 153 Vt. 479, 486-87 (1990).

First, petitioner claims that the Board's finding that J.M. was in medical distress prior to the emergency call is not supported by credible evidence. In support, petitioner relies on her own testimony that she saw J.M. at 9 p.m. on December 2, 2002 and that, at the time, he was not in distress. She also attempts to discredit the testimony of Middleton. We are not persuaded. The Board did not find petitioner's testimony credible, since she provided different accounts of when she had last seen J.M. The Board credited Middleton's testimony that he believed J.M.'s symptoms had been going on for some time, because J.M. told him that he had been having trouble breathing all day long, and J.M.'s clinical symptoms were consistent with a gradual decline in condition. As the finder of fact, the Board was charged with determining the credibility of witnesses and was free to credit Middleton's testimony over petitioner's. See In re Young, 134 Vt. 569, 571 (1976) (per curiam) (explaining that an administrative board must consider the credibility of witness and determine the weight to be given their testimony).

Petitioner's attempts to discredit Middleton's testimony are similarly unavailing. Petitioner claims that Middleton's testimony that J.M. gave him an account of his activities on December 2 contradicts Middleton's testimony that J.M. could not speak more than a word at a time. There is no contradiction, because Middleton explained that he gained the information from J.M. in response to specific questions, not as part of a lengthy explanation from J.M. Petitioner further alleges that Middleton did not describe any reasonable period of time in which J.M.'s symptoms would have been obvious to a lay person. Although Middleton did not give a specific time period, he explained that, based on J.M.'s statements and his own observations of J.M.'s medical condition, J.M. had been ill for the previous day and that his breathing difficulties should have been evident to staff at that time. This information was sufficient for the Board to find that J.M. was in medical distress prior to the emergency call.

Second, petitioner argues that there is no evidence to support the Board's finding that petitioner's unavailability during the emergency call amounted to neglect, because DAIL did not introduce any evidence that petitioner's presence would have made any difference and because she was not required to have an awake staff person at night. As to petitioner's first claim, even accepting petitioner's claim that her failure to be available during the emergency call did not result in any harm to J.M., we still conclude that the Board did not err in finding neglect. The statute defines neglect as, among other things, failure to "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." 33 V.S.A. § 6902(7)(A)(i). The statute further explains that "[n]eglect may be repeated conduct or a single incident which has resulted in or could be expected to result in physical or psychological harm." Id. § 6902(7)(B) (emphasis added). Thus, the statute does not require that a caregiver's actions result in actual harm to a vulnerable adult, but instead only that the actions "could be expected" to do so. Id. Here, the Board found, based on credible evidence, that emergency medical staff sought a staff person to obtain critical information about J.M.'s medical history and current medications. Their failure to obtain such information could have resulted in harm to J.M., and thus, the Board did not err in finding petitioner's failure to assist J.M. amounted to neglect.

Furthermore, while we recognize that because petitioner operates a Level IV residential care home, a staff member need not be awake at petitioner's home at all times, there was no error in the Board's finding that a staff member should have been available in the case of an emergency. DAIL's regulations require a residential care home, such as petitioner's, to have "a sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies." Agency of Human Services, Department of Aging and Disabilities, Residential Care Home Licensing Regulations, § 5.11.a, available at http://dail.vermont.gov/dail-statutes/statutes-dlp-documents/rch-licensing-regulations. In this case, there was evidence that petitioner did not respond when J.M. attempted to locate her or when the other resident tried to knock on her door. Further, when emergency personnel arrived, petitioner did not respond to the noises they created, the lights generated from the vehicles, or the specific attempts to find her. We conclude that this evidence is sufficient to support the Board's finding that petitioner was not available "to provide necessary care," id., in an emergency and that this failure constituted neglect. See also 33 V.S.A. § 6902(7)(A)(i) (defining neglect to include failure to provide necessary supervision and medical services).

Third, petitioner argues that the Board's finding that she failed to obtain necessary medication for J.M. was not supported by the evidence. Petitioner cites her own testimony, at the fair hearing, that she did not handle J.M.'s medication and that she believed the prescriptions had already been phoned into the pharmacy when J.M. returned from the hospital on December 7. In addition, petitioner claims that, as the operator of a Level IV residential care home, she is not required to administer medications.

We conclude that there was adequate evidence to support the Board's finding. While petitioner is not responsible for administering medication, her facility should provide "medication management." 33 V.S.A. § 7102(1)(B). In addition, under the statute, it is neglect for a caregiver to fail to "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." 33 V.S.A. § 6902(7)(A)(iii). The Board did not find to be credible petitioner's testimony on J.M.'s prescriptions, noting that petitioner's testimony on the subject was "confused" and "[h]er actions were inconsistent with her statement that she had no involvement with medications." The evidence supports the Board's findings that petitioner failed to obtain the prescriptions and this failure could have led to physical harm, as evidenced in part by his return to the hospital on December 9 for shortness of breath.

Finally, we address petitioner's remaining claim of error—that there is no credible evidence supporting the Board's finding that she neglected J.M.. Petitioner does not dispute that J.M. never received physical therapy but rather relies on her own testimony that she did contact the VNA after J.M. returned from the hospital on December 9 and that the VNA told her she would need a new order for physical therapy. We conclude that there was credible evidence to support the Board's decision. The Board was not persuaded by petitioner's account of why J.M. did not receive physical therapy or by petitioner's explanation of why J.M. was too weak to exit the bath unassisted. As the Board noted, there was no evidence that the order for physical therapy was ever cancelled. The Board relied instead on the investigator's report, which stated that the VNA had attempted to arrange for the therapy, and the undisputed fact that J.M. did not receive therapy. Petitioner's failure to assure that J.M. received physical therapy could have resulted in harm, as evidenced by J.M.'s weakness in being unable to get out of the bath. Therefore, the Board's finding of neglect was supported by the evidence. See id. (defining neglect to include a caregiver's to failure to "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").

Affirmed.

BY THE COURT:

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Paul L. Reiber, Chief Justice

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John A. Dooley, Associate Justice

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Brian L. Burgess, Associate Justice