COMMONWEALTH OF MASSACHUSETTS

DIVISION OF ADMINISTRATIVE LAW APPEALS

A.C.,
Petitioner

v. Docket No. DPPC-24-0599

Disabled Persons Protection Commission,
Respondent

Appearance for Petitioner:

A.C.

Appearance for Respondent:

Andrew Levrault
Deputy General Counsel
Disabled Persons Protection Commission

Administrative Magistrate:

Kenneth Bresler

SUMMARY OF DECISION

DPPC did not prove by a preponderance of the evidence that the petitioner committed abuse, abuse *per se*, or registrable abuse.

DECISION

The petitioner, A.C., appeals the determination by the Disabled Persons Protection Commission (DPPC) that she committed abuse *per se* of a disabled person, which constituted registrable abuse, that is, abuse that would place her on the registry of abusers.

I held a hearing on September 25 and 26, 2025 by Webex, which I recorded.

DPCC called as witnesses Staffer 1 and Staffer 2,[1] who provided direct care to the alleged victim and other residents in the alleged victim's group home; the director of residential services for the nonprofit that operated the alleged victim's group home; and an investigator for the Department of Developmental Services (DDS).

A.C. represented herself, testified, and called two witnesses, whose initials are D.R. and S.C., who worked with A.C. for about a year, providing direct care to H.Q., the alleged victim, and other residents. They testified about A.C.'s professional qualifications; they were not percipient witnesses to the alleged incidents.

I admitted 14 exhibits. Both parties submitted post-hearing briefs in November 2025.

Findings of Fact

H.Q.'s residence

1. H.Q., the alleged victim, lives in a group home on Cape Cod that a nonprofit organization operates. (Stipulation)

2. DDS licenses H.Q.'s group home[2] and coordinates and pays for her residential services. (Stipulation)

3. In April 2024, H.Q.'s group home had five female residents, including H.Q. (Stipulation; Staffer 2 testimony)

4. The group home has two floors that residents use. H.Q.'s bedroom is on the first floor. Staffers use the basement, but residents do not. (Staffer 2 testimony)

[1] The Initial Response Form and Investigation Report referred to Staffer 1 as I-3 and Staffer 2 as I-4. (Ex. B, p. 2; Ex. C, p. 2) Hearing participants referred to Staffer 1 by her initials, K.O., and Staffer 2 by her initials, K.R.

[2] This decision uses "group home" and "residence" interchangeably.

5. The shifts and typical staffing for the group home were as follows: The first shift was typically 7:00 a.m. to 3:00 p.m., with two and sometimes three staffers. The second shift was typically 3:00 to 11:00 p.m., with three staffers. The overnight shift was typically 11:00 p.m. to 9:00 a.m., with two staffers. (Staffer 2 testimony)

H.Q.

6. The alleged victim, H.Q., was in her 50s at the time of the alleged incidents. She has several disabilities, including post-traumatic stress disorder, a seizure disorder, a mood disorder, and an intellectual disability under 118 CMR 2.02. (Stipulation, Staffer 2 testimony)

7. H.Q. uses a walker and gait belt when ambulating, that is, walking. (Stipulation) A gait belt is a device that goes around a person's waist. It has handles on it that another person or other people can use to keep the gait-belt wearer steady or help her up. (Staffer 2 testimony)

8. H.Q. has a behavior profile that includes throwing herself on the floor when in a manic state or when mad. (Ex. B, p. 4; Ex. C, p. 4)[3] She commonly voluntarily slithered out of her chair, landing on her buttocks on the floor. (A.C. testimony)

9. H.Q. has knee protectors, because she falls often, whether on purpose or because she's at risk for falling. (Director testimony)

10. H.Q. often threw items at staff and other people, including her shoes and jewelry that she was wearing. (Ex. B, p. 4; Ex. C, p. 4)

11. When H.Q. escalates behavior, staff members' actions include taking jewelry off her and from her. (Ex. B, p. 4)

[3] The page numbers are the documents' internal page numbers, not the Bates-stamped numbers.

12. H.Q. cools down quickly and when she does, staffers return her jewelry. (Ex. B, p. 4; ; Ex. C, p. 5)

13. Due to H.Q.'s medical condition, which includes hand tremors, the way that she takes her medication involves her tilting her head back and a staffer pouring the medication from a paper medication cup into her mouth. The staffer gives H.Q. a water bottle or glass of water. H.Q. then drinks on her own. (Ex. C, p. 4)

14. H.Q.'s challenging behaviors include a history of calling 911 to get attention. (Ex. E, pp. 1-2)

15. When she called 911, H.Q. typically told police that she wanted to go to the hospital and staffers were not allowing her to go. On one trip to the hospital, she had medics stop so that she could get a hamburger. (Director testimony)

16. On weekdays, H.Q. attends a day program that Habilitation Assistance Corporation operates. (Stipulation) That organization is not to the same nonprofit that runs H.Q.'s residence.

<u>H.Q.'s ability to report accurately</u>

17. The director of residential services, who provides some direct care to group-home residents, has known H.Q. since fall 2019, when H.Q. arrived at the group home. (Director testimony)

18. H.Q.'s communications skills are limited. When I asked the director of residential services about H.Q.'s credibility, she answered carefully and indirectly. Her roundabout answer led me to reasonably infer that H.Q. has made accusations involving staffers and other people that other people would report differently. (Director testimony)

19. When S.C., a direct-care staffer at H.Q.'s group home, told the residential manager and director of residential services[4] about things that H.Q. reported, the manager and director would dismiss the reports with comments along the lines of: H.Q. makes things up. (S.C. testimony)

20. Nothing came of H.Q.'s reports that S.C. passed on to the residential manager and director of residential services, as far as S.C. knew, so she assumed that the reports were inaccurate or perceived to be inaccurate. In addition, S.C. reported to the residential manager and director of residential services about bruising on H.Q. As far as S.C. knew, nothing came of these reports. (S.C. testimony)

Bruising

21. The director of residential services testified, and I find as fact: "Bruises happen [to residents]. As long as we can have them [residents] explain, we don't make a big deal out of it, but we do mark them on body checks," referring to documents recording the results of staffers checking residents' bodies. "Minor bruises…happen to anyone who needs assistance. We do investigate every bruise." Part of the investigation is to find out whether a resident exercised or fell, causing a bruise. "Some minor bruising can happen." It's not always explainable. (Director testimony)

22. The Investigation Report, in a section called "Other injuries that were not the result

[4] The residential manager ran H.Q.'s group home. The Initial Response Form and Investigation Report referred to her as I-2 (Ex. B, p. 2; Ex. C, p. 2). Hearing participants referred to her by her initials, J.C. She did not testify. The director of residential services oversaw the nonprofit's multiple group homes, including the one that H.Q. lives in. The Initial Response Form and Investigation Report referred to her as PR-1. Hearing participants referred to her by her initials, M.G. She testified.

of an act/omission/abuse per se by a caretaker, or did not rise to the level of a serious injury as defined by 118 CMR," stated that H.Q.

> sustained several bruises on her upper arms, forearm, and elbow ranging from dime sized to 1" by 1.5", a dime sized bruise on her left thigh, and a "small" bruise behind her right ear.

(Ex. C, p. 13)[5]

MAP (Medication Administration Program)[6]

23. The residential manager and the director of residential services (who worked occasionally in H.Q.'s group home) were the only staffers who provided direct care at H.Q.'s group home and who were certified to administer medications to residents. (Ex. B, p. 4; Director testimony) According to the residential manager, "This causes severe hardship and has become very difficult to manage." (Ex. B, p. 4)

24. A.C. was not certified to administer medications. (Ex. B, p. 4)

25. Distribution of medications was called a med pass or meds pass, referring either to staffers' passing through the residence with medications for the residents, or staffers' passing out medications to the residents. (Staffer 2 testimony)

26. During the COVID-19 epidemic, MAP requirements were loosened or removed by the nonprofit than runs H.Q.'s residence, the Commonwealth of Massachusetts, or both; the

[5] It is unclear whether the investigator did not ascribe these bruises, or some of them, to A.C., or determined that the bruises, or some of them, did not constitute serious injuries. It is unclear why "small" is in quotation marks.

[6] This topic is not directly related to the issues on appeal. Although A.C. was not certified to distribute medications and nonetheless did so, DPPC has not proceeded against her on this ground.

director of residential services was not sure which entity did so and when the full MAP requirements were reinstated. (Director testimony)

27. In April 2024, A.C. was in the process of MAP training. (Director testimony) However, according to the director of residential services, A.C. was not taking her training seriously.[7] Although the non-profit typically gave staffers six months to get trained and training could be completed in two days, A.C. had not completed her training and become certified. (Director testimony)

28. Residents' medications were kept in a locked cabinet. According to the director of residential services, staffers who were not MAP certified typically did not have access to the locked cabinet's code. Typically, MAP-certified staffers used Facetime, a videochat feature, to walk non-MAP-certified staffers through which keys to the cabinet to use. (Director testimony)[8]

29. According to the residential manager, on April 4, 2024, both she and the director of residential services needed to accompany a resident to a medical appointment. She and the director of residential services gave permission to A.C. to administer medications. The residential manager prepared medications for A.C. to administer that morning. (Ex. B, p. 4; Ex. C, p. 5)

30. The nonprofit considered it acceptable for A.C. to pass meds because she was in the

[7] The director's tone during this part of her testimony was accusatory.

[8] It is unclear from the director of residential services' testimony whether the cabinet was locked by a code or by keys. It is also unclear what she meant by staffers' not having access to the code "typically." That the typical staffer did not have access to the code? That staffers sometimes had access to the code?

process of getting MAP certified. (Director testimony)[9]

31. A.C.'s passing meds was a violation of MAP, which the nonprofit later "addressed." (Director testimony)[10]

32. Around April 2024, the director of residential services spoke to the residential manager and ordered an end to the practices of prepouring medications and allowing non-MAP-certified staffers to administer them. ("Prepouring" referred to preparing medications, both pills and liquids, for distribution.) (Director testimony)

33. The nonprofit's addressing the problem of non-MAP-certified staffers administering medications included the residential manager's receiving oral feedback; the director testily denied that the manager received a reprimand, which she stated the nonprofit did not engage in. (Director testimony)

34. When the investigator learned about the group home's practice, she was shocked. She recommended that DDS conduct a MAP audit and inspect the group home, unannounced, around med-passing times. (Investigator testimony; Ex. C, p. 13)

35. The investigator called the nonprofit's allowing the residential manager to sign the Medication Administration Record, indicating that she had distributed medications (Ex. G),

[9] Thus, the reason or reasons why A.C. was allowed to administer medications to H.Q., even though she was not MAP certified, was or were amorphous and implied: Requirements under MAP had been loosened or removed and possibly not reinstated; A.C. was in the process of getting certified and therefore was not completely unqualified to pass meds; and the group home had no one else to administer medications.

[10] That is how the director initially testified. I later asked her questions to determine who had addressed the violation, when, and how. The director's initial testimony could have left the possible impression that A.C. was responsible for the violation, which (1) I find was not the case and (2) is not directly an issue in this appeal, as I have stated.

when someone else had performed the meds pass, “outrageous” and said that nonprofit was trying to cover up. (Investigator testimony)

Overview of alleged incidents

36. On April 4, 2024, A.C. allegedly forced H.Q. to take her medications. A.C. allegedly did so twice, once in the morning and once in the evening. (Exs. B, C)

37. H.Q. and the other residents in H.Q.’s group home were allowed to refuse medications. (Staffer 2 and Investigator testimony)

Overview of investigation

38. On April 5, 2024, a DDS investigator, Lisa Gillum, was assigned to investigate the allegations. (Ex. B, p. 1)

39. On April 9 through 11, 2024, the investigator interviewed various witnesses, including H.Q., but not A.C. (Ex. B, p. 2)

40. On April 16, 2024, the investigator signed DPPC’s Initial Response Form (Ex. B, p. 6)

41. On April 24, 2024, the investigator interviewed A.C., who had been on vacation. (Ex. C, p. 2)

42. On June 12, the investigator signed DPPC’s Investigation Report Form. (Ex. C, p. 21)

The alleged morning incident

H.Q.’s report to the investigator

43. H.Q. told the investigator[11] or the investigator observed:

[11] I put it this way and use similar phrasing below because I do not find the allegations to be factual.

A. Because A.C. had taken away her jewelry,[12] H.Q. was mad, screaming, having a behavior, and did not want to take her medications. A.C. grabbed H.Q.'s cheeks tightly, yelled at her, grabbed her wrist, causing a bruise, and forced her to take her medications. H.Q.'s cheeks were still sore from A.C.'s grip; the bruise was still painful. (The investigator interviewed H.Q. on April 11, 2025, eight days after the alleged incident. That is, H.Q.'s cheeks and bruise still hurt more than a week later.) (Ex. C, p. 7)

B. H.Q. was unable to clearly recall the incident of A.C. bringing her down to the floor on the morning of April 4, 2024. She confused it with another time when she put herself on the floor. (Ex. C, p. 7)

C. H.Q.'s left forearm had a round, nickel-sized bruise; her left forearm near her wrist had a round, quarter-sized bruise. (Ex. C, p. 7)

D. During the incident, H.Q. felt upset, scared and angry. (Ex. C, p. 7)

Staffer 1's report to the investigator and testimony

44. Staffer 1 told the investigator, testified, or both as follows:

[12] A.C. did not take away H.Q.'s jewelry; she did not work on the night that a staffer took away H.Q.'s jewelry. (A.C. testimony) It is unclear who took away H.Q.'s jewelry; it was probably the residential manager. (A.C. testimony) The investigator reported Staffer 1's narrative in the passive voice: H.Q. asked "for her jewelry, which had been taken away the night before…." (Ex. C, p. 6) More than once, the use of the passive voice in the investigation and hearing, whether intentional or unintentional, obscured who had acted. (Staffer 2's testimony lapsed into the passive voice at least twice.)

When the investigator interviewed H.Q., the residential manager was present at H.Q.'s request, which may have influenced H.Q.'s answers. (Ex. C, p. 7; Investigator testimony). If the residential manager had taken away H.Q.'s jewelry, H.Q. might not have named the manager to the investigator.

A. A.C. is bossy, demanding, and often very short with H.Q., who does not like or respond well to A.C.'s shortness.

B. In the morning of April 4, 2024, A.C. seemed annoyed with H.Q. and spoke to her with an aggravated tone.

C. H.Q. asked for her jewelry, which had been confiscated the night before. A.C. said that she could not have it.

D. At 7:30 a.m., A.C. told H.Q. that she had to have her pre-breakfast medication. H.Q. initially refused.

E. Soon afterward, A.C. approached H.Q. again and loudly said, "Take your meds!"

F. H.Q. refused again. A.C. forcefully pushed H.Q.'s head back, squeezed her cheeks to force H.Q. to open her mouth, poured medications into H.Q.'s mouth, and took a water bottle and poured water into H.Q.'s mouth.

G. During the incident, H.Q. resisted and swatted at A.C., who swore and yelled at H.Q., telling her to stop resisting.

H. A.C. told Staffer 1, "Hold her hands down!" Staffer 1 did so to keep H.Q. from swatting at A.C.

I. H.Q. sputtered and coughed at A.C. while A.C. poured water into H.Q.'s mouth. H.Q. swallowed the medications.

J. H.Q. stood up and said, "I'm leaving!" H.Q. continued to swat at A.C., who grabbed H.Q. by the arms and roughly pulled her down to the floor.

K. H.Q. was in a sitting position. She was unable to get up on her own. She began trying to get up; Staffer 1 began helping her. A.C. yelled at Staffer 1, "No, I'll do it!"

L. A.C. told H.Q. to wait until she calmed down.

M. H.Q. tried to pull herself up from the floor using a cardboard box that was on the floor, which flipped onto her thigh. (Ex. C, p. 6)

N. H.Q. was angry, yelled and swore at A.C., and threatened to leave the residence.

O. Approximately 10 minutes later, when H.Q. stopped yelling and told A.C. that she was ready, A.C. helped her up.

P. H.Q. told A.C. that she was going to report the incident to the residential manager and director of residential services. A.C. said that everyone hated H.Q., and the residential manager and director of residential services would not believe her. (Ex. C, p. 6)

Q. On April 7, 2024, H.Q. showed Staffer 1 bruises on her left arm and stated, "Staff grabbed me." Staffer 1 believed that A.C. caused the bruises by grabbing H.Q. on April 4, 2024. While assisting H.Q. with personal care, Staffer 1 saw a dime-sized bruise on H.Q.'s thigh which she believed was caused when the box flipped onto H.Q.'s leg.

R . Staffer 1 expressed remorse for not intervening and stated that she had been scared.

S. Staffer 1 did not record the incident in the residence's communications log. (Ex. C, p. 6; Ex. O; Staffer 1 testimony)

Staffer 1's demeanor during her testimony

45. Staffer 1 began her testimony looking anxious, even anguished. I told her that she

looked a little bit nervous (she actually looked very nervous) and I tried to reassure her by telling her that she could consider the hearing as a Zoom meeting and that all that would happen was that she would be asked what she knew and remembered. I rarely give witnesses such a reassurance or feel the need to do so. Staffer 1's face later grew beyond anguished to pained.

Factual findings/A.C.'s hearing testimony[13]

46. A.C. testified as follows, and I find as fact the following:

47. On April 4, 2024, the residential manager prepoured H.Q.'s morning medications and instructed A.C. to do the meds pass. (A.C. testimony)

48. When A.C. offered H.Q. her single pre-breakfast pill, H.Q. initially refused. Later, A.C. returned to her and H.Q. eventually took her pill. (A.C. testimony)

49. However, when A.C. returned to H.Q. with H.Q.'s morning medications (her *post*-breakfast medications) H.Q. started swatting at A.C. She grabbed A.C.'s hand. A.C. used a finger grip to remove H.Q.'s hand, a move that A.C. was trained in that entailed using her thumb to pry off H.Q.'s hand. (A.C. testimony)

50. After a few minutes, A.C. returned and offered H.Q. her medications again. H.Q. swatted at her again. H.Q. slithered herself out of the chair and to the ground. (A.C. testimony)

51. A.C. let H.Q. stay on floor for about 10 minutes, returned, and again offered H.Q. her medications. H.Q. took her medications. A.C. did not force H.Q. to take her medications. (A.C. testimony)

[13] I put "Factual findings" in this and other headings below because I credit A.C.'s testimony on these points.

52. Sometimes H.Q. does not open her mouth enough for meds, and A.C. put a finger on her chin to encourage her to open her mouth wider, as A.C. has done in the past. (A.C. testimony)

The alleged evening incident

What H.Q. told the investigator[14]

53. H.Q. apparently did not discuss the alleged evening incident with the investigator; she discussed only the alleged morning incident. (Ex. B, p. 5; Ex. C, p. 7)

54. The investigator testified that H.Q. was unable to distinguish between the two alleged incidents. (Investigator testimony)

Staffer 2's report to the investigator and testimony

55. Staffer 2 told the investigator, testified, or both as follows:

A. On April 4, 24, in the evening, Staffer 2 was upstairs in the residence, giving a shower to a resident.

B. When Staffer 2 was done, at approximately 8:30 p.m., she went downstairs and was told (the Investigation Report does not say by whom, although it may have meant A.C.) that H.Q. had refused to take her medications. Alternatively, H.Q. was loud and yelling, which brought Staffer 2 to her room.[15]

C. A.C. was aggressive, forceful, and loud, and yelled and swore at H.Q.

D. H.Q. was in a chair in her first-floor bedroom. She was refusing to take her

[14] H.Q. did not testify.

[15] These two alternatives are not necessarily inconsistent or even alternatives, considering that the Investigation Report paraphrased what Staffer 2 recounted.

medications. A.C. was instructing her to take her meds. A.C. squeezed H.Q.'s cheeks, forced her head back, jammed the medications into her mouth, held her mouth open, and poured water into it.

E. H.Q. kicked her legs and tried to move her head side to side, resisting A.C. Her face turned red.[16]

F. H.Q. struggled, swatted at A.C., made a gurgling sound as A.C. forced water into her mouth, and yelled, "Help!"

G. Staffer 2 gently blocked H.Q.'s hands from swatting A.C.

H. Staffer 2 felt very bad for H.Q.

I. Staffer 2 realized that A.C. should not be forcing H.Q. to take her medications. Staffer failed to intervene because she was worried about how A.C. would react, and she did not know what to do. (Ex. C, p. 7) Alternatively, although Staffer 2 was shocked and considered A.C.'s acts to be abusive and although she is a mandated reporter, she did not report A.C.'s actions at the time and did not have a good reason for not having done so.

J. She regretted not having intervened and regretted not having reported it. (Staffer 2 testimony)

K. Staffer 2 did not record the incident in the communications log.

L. The residential manager was in the group home at the time, in the basement.[17] Staffer 2 should have summoned her, but did not.

(Ex. C, p. 7; Staffer 2 testimony)

[16] Staffer 2 testified to these details, but they do not appear in the Investigation Report.

[17] Staffer 2 did not testify how she knew this.

What the residential manager told the investigator[18]

56. The residential manager told the investigator the following:

A. On April 4, 2024, the residential manager had given A.C. permission to administer medications to H.Q. and other residents for that morning only.

B. In the evening, the residential manager was administering medications. H.Q. refused to take her medications. The residential manager replaced the cup with H.Q.'s medication in the locked medication cabinet; she planned to wait 15 minutes and try to give H.Q. her medications again.

C. When the residential manager returned to the cabinet, the cup with H.Q.'s medications was gone. She went upstairs and learned from staffers that A.C. had given H.Q. her medications.

D. The residential manager asked A.C. about this report; A.C. "had no real response, no explanation"[19] why she had done so. The residential manager advised A.C. that this was not acceptable.

Factual findings/A.C.'s hearing testimony

57. A.C. does not have the code to the medications cabinet. (A.C. testimony)

58. In the evening of April 4, 2024, A.C. dd not administer medications; the residential manager did so. (A.C. testimony)

[18] As stated above, the residential manager did not testify.

[19] This quotation is apparently the investigator quoting the residential manager who was paraphrasing A.C.'s response.

Investigation of the alleged incidents

59. On April 5, 2024, the day after the alleged incidents, H.Q. showed bruising on her left forearm to a staffer at her day program. (Ex. H)

60. The staffer brought the day-program nurse to H.Q. to see the bruising. (Ex. H)

61. When the nurse asked H.Q. about the bruising, H.Q. began crying. (Ex. H)

62. The nurse and H.Q. moved to the nurse's office. (Ex. H)

63. H.Q. told the nurse the following:

A. A residential staffer had hit, grabbed her, and thrown her to the floor. (Ex. H)

B. While H.Q. was on the floor, the staffer grabbed her cheeks and forced her to take her medication. (Ex. H)

C. H.Q. kicked, hit, and swore at residential staff because she was upset.

D. The residential staff had taken all of H.Q.'s jewelry and told her that she could not visit her sister.

E. H.Q. was afraid to return to the group home.

(Ex. H)[20]

64. The nurse found H.Q. to be credible because H.Q. acknowledged her own behavior, reporting that she yelled and swore at residential staff because they took her jewelry away and told her that she could not visit her sister. The nurse reported that H.Q. was very upset and was able to return to baseline (her usual temperament) approximately 15 to 20 minutes after their discussion. (Ex. B, p. 4)

[20] The Investigation Report and the investigator's testimony included minor details that are inconsistent with the nurse's notes, such as that H.Q. initiated the conversation with the nurse. (Ex. C, p. 4)

65. According to a slightly different account, a day-program staffer noticed bruising on H.Q.'s arm. The staffer asked about it. H.Q. answered that a residential staffer had grabbed her, pulled her to the floor, squeezed her cheeks, and forced her to take medication. The staffer took H.Q. to the nurse. H.Q. repeated her account to the nurse. Later, the nurse told the investigator that H.Q. was very upset, crying, didn't want to go back to group home, and didn't want to see the staffer who forced her to take her medications. (Investigator testimony)

66. The nurse called the residential manager and director of residential services, who both went to the day program and picked up H.Q. (Investigator testimony, Director testimony)

67. H.Q. was crying, agitated, and upset. She said that she was afraid to return to the group home. She pointed out the bruising on her arms[21] and said: Look what she did to me. (Director testimony)

68. The director of residential services asked H.Q. who had caused the bruising. H.Q. struggled to find the name of the staffer responsible. H.Q. said that the staffer's name starts with "S." The only person on the residential staff whose name starts with "S" was on family leave, was not working at the residence, and had not worked there for about three months. (Director testimony)

69. The director of residential services named staffers who had been working the previous morning.[22] When the director mentioned A.C., H.Q. lit up and said: That's her, that's her. (Director testimony) (A.C.'s first name does start with the letters "As.")

[21] While the Investigation Report referred to one bruise (Ex. C, p. 4), the director of residential services to testified to bruising on both arms.

[22] H.Q. did not recount the alleged evening incident.

70. The nurse and the residential manager took photographs of H.Q.'s bruises. (Exs. I & J)

71. The photographs depict multiple bruises. The director of residential services suspected that the bruises were from H.Q.'s being grabbed at the back of her elbow. (Director testimony)[23]

72. The director of residential services took H.Q. to the doctor. (Ex. H)

73. A.C. was suspended, then terminated. (Director testimony)

74. On April 9, 2024, five days after the alleged incidents, the residential manager told the investigator that several new bruises had emerged on H.Q.'s arms and a yellow bruise had emerged behind her ear. (Ex. C, p. 5)

75. Two residential staffers, the investigator wrote, "have come forward and disclosed observations of [A.C.] physically forcing [H.Q.] to take her medications." (Ex. B, p. 4) The investigator did not reveal when and how Staffer 1 and Staffer 2 came forward.

Procedure

76. On or around June 12, 2024, DPPC issued an Investigation Report that:

A. substantiated a finding of abuse *per se* against A.C. based upon her committing the intentional, wanton, or reckless application of a physical force on H.Q., which resulted in pain to H.Q.;

B. substantiated a finding of abuse against A.C. for committing acts that caused H.Q. to suffer a serious emotional injury; and

[23] It is unclear which bruises in the photographs the investigator did not ascribe to A.C. or determined did not constitute serious injuries. (Ex. C, p. 13)

C. determined that AC had committed registrable abuse. (Stipulation)

77. On June 17, 2024, DPPC mailed to A.C. a Notice of Right to Respond, the investigative response, and instructions for filing a Petition for Review. (Stipulation)

78. On June 22, 2024, A.C. timely submitted a Petition for Review, contesting DPPC's findings. (Stipulation)

79. On August 29, 2024, DPPC issued its Decision on the Appellant's Petition, affirming the findings of the Investigation Report. (Answer of DPPC, letter of Assistant General Counsel, p. 10)

80. On September 18, 2024, A.C. timely appealed to the Division of Administrative Law Appeals. (Stipulation)

Discussion

DPPC did not prove by a preponderance of the evidence that the two alleged incidents happened. I doubt that they happened for the following reasons.

H.Q. did not discuss the evening incident with the investigator. She was confused while discussing the alleged morning incident with the investigator. (Ex. C, p. 7)

H.Q. apparently discussed one alleged incident, not two alleged incidents, with the nurse. (Neither person testified.)

H.Q. revealed one alleged incident to a staffer and nurse at her day program on the day afterward. That is, if the two incidents occurred as DPPC has alleged, A.C. forced H.Q. to take medications in the morning of April 4, 2024; H.Q. went to her day program on that day without revealing the alleged incident, exhibiting distress, or without day-program staff noticing H.Q.'s distress; and A.C. again forced H.Q. to take medications in the evening of April 4, 2024. Only on

April 5, 2024 did H.Q. reveal one alleged incident and tell the nurse, the residential manager, and the director of residential services that she was afraid of returning to her residence.

When the director of residential services asked H.Q. who had caused the bruising, H.Q. struggled to name the responsible staffer and said that the staffer's name starts with "S." However, the only staffer whose name starts with "S" had not worked there for about three months. (Director testimony)

Although I did not and could not evaluate H.Q.'s credibility by hearing and seeing her testify, the evidence did not bolster her credibility. She has a history of calling 911 to get attention. (Ex. E, pp. 1-2) As far as S.C. knew, the nonprofit did not act on H.Q.'s reports and considered them noncredible. (S.C. testimony) The director of residential services did not directly answer my question about whether H.Q. is credible.

Staffers 1 and 2, who were both mandated reporters, did not report the incidents to supervisors or record them in the communications log. (Ex. O) Eventually, they "c[a]me forward and disclosed observations" (Ex. B, p. 4), but the circumstances of their doing so are not in evidence.

Staffer 1's face during her testimony was anxious, anguished, and pained, as if she were testifying untruthfully and knew it. She could have been anguished by the hearing itself and by recounting an upsetting incident of abuse, but I think that is the less likely explanation.

Since the 7:00 a.m. to 3:00 p.m. shift had two and sometimes three staffers, and the 11:00 p.m. to 9:00 a.m. shift had two staffers (Staffer 2 testimony), during the alleged morning incident around or after 7:30 a.m., possibly four or five staffers were present, including Staffer 1 and A.C. Yet only Staffer 1 testified for DPPC.

The residential manager, who was present during the alleged evening incident, did not hear the commotion, including H.Q.'s yelling "Help!," from either the basement (where Staffer 2 testified the residential manager was), the first floor (where the alleged incident occurred), or the second floor. If the residential manager did hear the alleged incident, she didn't respond.

The residential manager did not report to the investigator that she heard this alleged incident as it happened. Nor did she testify.

Since the residential manager, who was MAP-certified, was present during the evening, A.C., who was not MAP-certified, had no reason to distribute medications. A.C. did not have the code to the medications cabinet. A.C. had no reason to *force* H.Q. to take medications in the evening if (1) H.Q. had resisted so vociferously in the morning and (2) the residential manager was present in the evening.

Bruising happens to group home residents, sometimes for routine reasons, sometimes for unknown reasons. (Director testimony) H.Q.'s bruises cannot necessarily be attributed to A.C. (Ex. C, p. 13) The fact that H.Q. was bruised (Exs. I & J) does not prove that A.C. abused her.

A.C.'s testimony about the morning of April 4, 2024 was calmer, sometimes more insistent, and ultimately more believable than Staffer 1's testimony. A.C.'s testimony about the evening of April 4, 2024 – that no such incident occurred – holds together better and is ultimately more believable than Staffer 2's testimony.

DPPC argued in its brief, "Staffer 1 had no reasons to fabricate this report. She did not harbor any ill-will towards the Petitioner…." (DPPC Br. 35) It is true that the evidence does not reveal that Staffer 1 had any reason to fabricate the report. She had no known ill will toward A.C. But those observations go only so far. Too many factors undermine the possibility that the

two alleged incidents happened for me to find a preponderance of evidence.

Preponderance of the evidence means that it is "more probable than not" that the alleged incident occurred. *Continental Assurance Co. v. Diorio-Volungis*, 51 Mass. App. Ct. 403, 409 n.9 (2001); *J.L. v. Disabled Persons Protection Commission*, DPPC-22-0415, 2023 WL 7402532 (Div. Admin. L. App., Nov. 1, 2023). It is *not* more probable than not that A.C. forced H.Q. to take medications twice or even once.

I don't know why Staffers 1 and 2 testified as they did, why staffers at the group home and nonprofit seem to be arrayed against A.C., and why the residential manager, who seemed would have been a key witness, did not testify. The group home and nonprofit seem to have problems. The investigator even accused the nonprofit of covering up its MAP violations and suggested further investigation, not of A.C., but of the nonprofit.

I don't know if the group home's and nonprofit's possible problems are somehow related to the allegations against A.C. – if for instance, A.C. was a scapegoat or a way to deflect attention from possible problems. But those possibilities are not before me. My task is to determine whether A.C. committed the allegations against her. I find that the preponderance of the evidence does not support the allegations. I can and do make that finding without having to also find why these allegations, which do not withstand scrutiny, were nonetheless made.

Conclusion and Order

The Disabled Persons Protection Commission has not proved by a preponderance of the evidence that A.C. committed abuse or abuse per se of a disabled person, which constituted registrable abuse. DPPC may not place A.C. on the registry of abusers.

Dated: December 5, 2025

/s/
_____
Kenneth Bresler
Administrative Magistrate
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