THE COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss. Division of Administrative Law Appeals

Andrew Lawrence,
Petitioner

v. Docket No. PHNA-24-0671

Department of Public Health,
Respondent

Appearance for Petitioner:

Andrew Lawrence, pro se

Appearance for Respondent:

Ryan T. Gibbons, Esq.

Administrative Magistrate:

Kenneth J. Forton

SUMMARY

The Department of Public Health has proven that Petitioner, a certified nurse aide, sexually abused three nursing home residents under his care. His name shall therefore be placed on the abuse Registry.

DECISION

Pursuant to 42 U.S.C. §§ 1396r and 1395I-3; G.L. c. 111, §§ 72F-72L; and 105 CMR 155.000, *et seq.*, Respondent Department of Public Health (DPH) filed a complaint investigation report with respect to Petitioner Andrew Lawrence, a licensed certified nurse aide, following a finding that he had sexually abused 5 residents under his care at

a long-term care facility in Northampton, Massachusetts. Mr. Lawrence requested an adjudicatory hearing to challenge DPH's finding.

A hearing was held at DALA on March 27, 2026. It was digitally recorded on the Webex video platform. I entered 11 documents into evidence, though Exhibits 10 and 11 (2 supportive letters) had not been submitted yet. At the conclusion of the hearing, I left the record open for Mr. Lawrence to submit those 2 letters from his former coworkers. Only one, Iesha Santos, followed through; her statement was pre-marked as Ex. 10. Consequently, there is no Ex. 11. (Exs. 1-10.) DPH Complaint Unit Investigator Colleen Burque and Nurse Kwame Asamoah testified on behalf of DPH. Respondent testified on his own behalf.

In lieu of testimony, the parties agreed to depose Residents 1, 2, and 4 and submit their depositions as hearing exhibits. Exhibits 5 and 6 are the depositions of Residents 2 and 4, respectively. I did not admit Resident 1's deposition because, during its course, it became clear that Resident 1 had been medicated just before the deposition began and consequently she was not competent to testify at that time. The parties abandoned the deposition after her condition became apparent.

DPH has chosen not to pursue its claim as to Resident 3 because she has died, and it has likewise chosen not to pursue its claim as to Resident 5 because of its concerns regarding her mental competence at the time of the alleged conduct. Despite not being able to rely on her deposition, DPH *is* still pursuing its claim as to Resident 1 because it concluded, as I do, that she was competent at the time of the alleged conduct and she gave multiple reliable contemporaneous reports of what happened.

The parties filed closing briefs.

FINDINGS OF FACT

Based on the testimony and documents presented at the hearing, I make the following findings of fact:

1. Andrew Lawrence is a certified nurse aide (CNA). (Testimony Lawrence; Exs. 2, 9.)

2. Mr. Lawrence had been employed at Highview of Northampton, a long-term care facility in Northampton, Massachusetts. He was eventually terminated, and the facility eventually closed. (Testimony Asamoah, Lawrence; Exs. 2, 9.)

Resident 1

3. Resident 1, aged 77, was admitted to Highview on June 24, 2022. (Ex. 8, p. 190.)

4. Her diagnoses included depression, anxiety, PTSD, chronic low back pain, and generalized weakness. (Ex. 8, p. 210.)

5. At the time of the subject incident, Resident 1 was cognitively intact and alert and oriented to time, place, and situation. (Ex. 8, p. 204.) Her most recent cognitive exam results indicated that Resident 1 did not show signs of cognitive impairment. (Ex. 1, p. 11.)

6. As a result of chronic pain, dizziness, and anxiety, Resident 1 needed a walker for ambulation. She was generally independent with ambulation but required continual supervision when fatigued. (Ex. 8, p. 190.)

7. Despite some physical limitations, staff considered Resident 1 independent with most tasks. (Exs. 2, 7.) They noted that she strongly preferred doing things on her own, so much so that her care plan included directives to encourage her to ask for help with getting out of bed. (Ex. 7, p. 149; Ex. 8, p. 194; Testimony Asamoah.) She required assistance with transfers, e.g., rising from sitting to standing and transferring on and off the toilet. She preferred to wear pull-ups as a precaution (Ex. 1, p. 15), but she was not incontinent. (Ex. 8, p. 223.)

8. Residents 1 and 3 were roommates. At 3:00 a.m. on the morning of July 28, 2024, Mr. Lawrence entered their room. He approached Resident 1, who was lying in her bed, and told her that she needed to have her brief changed. He began to undress her. She told him that her brief was not wet and that she was independent and did not need assistance. She told Mr. Lawrence to "stop" and to "leave her alone," but he continued to pull her toward the bathroom, insisting on changing her. Once in the bathroom, Mr. Lawrence put his hand in Resident 1's pull-up and inserted a finger in her vagina. He then brought Resident 1 back to her bed and left the room. (Ex. 4; Ex. 1, p. 4.)

9. Resident 1 reported that Mr. Lawrence's actions "shocked" her and made her "feel used." Because she was in shock, she did not immediately report the assault to Anne Schermerhorn, who was on duty as the night nurse during that shift. Instead, she went back to sleep. (Ex. 4.)

10. Resident 1 first reported the assault to Kwame Asamoah, a registered nurse at the Facility, who had worked at the Facility since 2021. During his time there,

he became very familiar with Resident 1 and was part of her care team. He described her as being "particular" about her routine. She wanted her medication administered exactly on time and she wanted her room kept very clean. Mr. Asamoah described her as a "usually independent lady" who liked to do things for herself. (Testimony Asamoah.)

11. Around 10:00 a.m. on July 28, 2024, Resident 1 approached Mr. Asamoah who was at the medication cart by the nurse's station. To him, she looked scared and shaken up, "like something really happened to her." She told him that at 3:00 a.m. that morning, a man in blue scrubs came into her room, woke her up from sleeping, and insisted on changing her. She then stated that the man took her to the bathroom, pulled down her brief, and inserted a finger into her vagina. Mr. Asamoah immediately reported this to Dennis Billings, the facility administrator; Anne Nadeau, the Director of Nursing Services; and the Northampton Police Department. (Testimony Asamoah.)

12. During her conversation with the police, Resident 1 reported that at 3:00 a.m. that day, a tall white male with blue scrubs entered her room, took her shirt off, groped her breasts, and then pulled her into the bathroom and inserted a gloved finger into her vagina. She identified the man as Mr. Lawrence. Consistent with her previous statements, Resident 1 told the police that she told Mr. Lawrence multiple times to stop, that she was independent, and that her brief was not wet. The police report described Resident 1 as looking "distraught." (Ex. 9.)

13. On August 1, 2024, detectives from the Northampton Police Department took another statement from Resident 1. The detectives' report notes that the details

of the assault that she provided to the detectives were very similar to how she described them to the police officers who started the investigation, as well as to facility staff. (Ex. 9.)

14. Resident 1 also provided a handwritten and signed statement describing her assault. (Ex. 4.) The details of this statement are consistent with her report to Mr. Asamoah (Testimony Asamoah), the statement she provided to Ms. Nadeau, the statement she provided to police, and what she reported to her medical providers. (Ex. 8.)

15. Resident 1 reported to her medical providers that she was shaken up by the incident. On July 29, 2024, Resident 1 was diagnosed with "adult sexual abuse, confirmed." That same day, her care plan was revised to reflect this new diagnosis. Her updated care plan stated that she was at risk for psychosocial decline and/or trauma secondary to an incident with staff. Signs and symptoms of this diagnosis are fear, pain, hypervigilance, flashbacks, and sleep disturbances. Staff interventions for dealing with this trauma include encouraging her to use quiet areas to decrease stimulation. The goal of the changes to her care plan was to reduce the risk of re-traumatization before the next care plan review. (Ex. 8, p. 198.)

16. DPH Investigator Colleen Burque investigated the incident. At various times with Ms. Burque, Resident 1 could not remember Mr. Lawrence's name. It did not strike Ms. Burque as unusual that she did not initially recall Mr. Lawrence's name, as Resident 1 usually did not receive care from the night staff. Ms. Burque observed that

Resident 1 was apprehensive and had difficulty talking about it. She said she felt "used" and "molested." (Testimony Burque.)

17. In defense against Resident 1's allegations, Mr. Lawrence has repeatedly stated that she was "accusatory," meaning that she had a history of making false allegations against staff members. The evidence does not support this accusation. According to her medical providers at the Facility, Resident 1 had no history of accusatory behavior and was a reliable historian. Mr. Asamoah, who had known Resident 1 for several years from his work at Highview, could not identify a single instance of Resident 1 making a false allegation against an aide. He characterized her as being particular about her care and vocal about concerns. But at no point did she accuse anyone of abuse. Mr. Lawrence could name only a single instance of behavior that resulted in negative consequences for an aide. It involved a complaint about Resident 1 not getting her medication when she wanted it. (Testimony Lawrence.) The medical records, care plan, witness statements, and testimony in this case show that Resident 1 was not known for engaging in "accusatory" behavior. (Exs. 3, 7, 8, 9; Testimony Burque, Asamoah.)

Resident 2

18. During the Facility's investigation of Resident 1's allegations, facility and police investigators conducted interviews with residents on the unit where Mr. Lawrence worked, asking if any other residents had had a similar experience with him. Resident 2 responded that she had. (Exs. 1, 2, 9.)

19. Resident 2's diagnoses included major depressive disorder, chronic respiratory failure, and incontinence of bladder and bowel, and she requires moderate assistance from staff with hygiene. She was cognitively intact. Resident 2 described herself as a "heavy wetter" who received multiple changes throughout the day. On occasion, Mr. Lawrence would change her when he was working. (Ex. 5.)

20. Mr. Asamoah, who also provided nursing care to Resident 2, described her as a "laid back resident" who expressed her concerns when she had them. Following the closure of Highview, Mr. Asamoah started working at a nursing home in Westfield, Massachusetts, and Resident 2 eventually moved there. Throughout the time that Mr. Asamoah has known her at both facilities, she was never known to be accusatory. (Testimony Asamoah.)

21. Resident 2 reported two incidents of abuse involving Mr. Lawrence. On an unspecified date in July 2024, at approximately 3:00 a.m., he entered her room to perform incontinence care. (Ex. 3.) While doing so, Mr. Lawrence lifted her gown up in a manner that was not typical of changes and exposed her genitals for his viewing. He then placed his hand on her vagina, and asked her, "can you feel it?" (Ex. 5.)

22. During the second incident at some time between 6:00 and 7:00 a.m., roughly a week before the incident involving Resident 1, Mr. Lawrence inserted a finger into her vagina during what was supposed to be a brief change. Mr. Lawrence similarly asked her, "do you feel that?" Resident 2 stated that the touching "threw her." She said that she could not move, so she closed her eyes and looked away. (Ex. 5.)

23. Resident 2 first reported the incidents to Director of Nursing Nadeau. (Ex. 5, p. 76; Ex. 3, p. 43.) She later reported them to the police. (Ex. 5, p. 78.) A police report described her as lucid and able to answer simple questions to a satisfactory level. (Ex. 9, p. 248.) She reported that a CNA named Andrew "went into [her] vagina" and asked her, "do you feel that?" (*Id.*)

24. On July 29, 2024, Resident 2 was examined by her clinician, Terri Morris, NP. She was diagnosed with adult sexual trauma, and her care plan was updated to reflect this change. (Ex. 8, p. 237.)

25. Mr. Lawrence accused Patient 2 of being accusatory, as well. None of the records in evidence supports that view. (Testimony Burque.) Mr. Lawrence could cite only one example of accusatory behavior: accusing a CNA of not changing her brief. (Testimony Lawrence.)

26. Mr. Lawrence also claimed that it would have been impossible for him to do what he was accused of because Resident 2's care plan called for two workers to change her, and thus it would have been impossible for him to be alone with her. (Testimony Lawrence.) Her care plan did specify that she required two people to assist, but this does not mean that Mr. Lawrence adhered to it. Resident 2 gave consistent, reliable testimony about the core facts of what Mr. Lawrence did to her. (Ex. 5.)

Resident 4

27. Resident 4's diagnoses included major depressive disorder and autistic disorder. Medical records indicate that Resident 4 was alert, had the ability to express her needs, was moderately cognitively impaired, was incontinent, and required

maximum assistance from staff with toileting hygiene. (Ex. 2.) Mr. Lawrence changed her regularly, sometimes alone. (Ex. 6, pp. 106-07.) They had a comfortable rapport and would discuss personal matters. (*Id.* at p. 108.) Resident 4 noticed that Mr. Lawrence acted differently when he started to close the door behind him to make changes. (*Id.* at 112.) This would usually happen at approximately 3:00 a.m. (*Id.* at 113.) Gradually he turned friendly chatter into sexual overtures, such as telling her that she "has big tits." (*Id.* at 115.)

28. At 3:00 a.m. one morning on an unspecified date in July, Mr. Lawrence, after talking about her breasts, showed Resident 4 that he had an erection under his uniform. (Ex. 6, p. 116.) He then offered to show Resident 4 his genitals; she agreed. (*Id.*) She testified to a particularly graphic description of Mr. Lawrence's genitals. (*Id.* at 117.) This graphic description was identical to the one she gave in an interview with Investigator Burque. (Ex. 7.)

29. Unlike the other residents, Resident 4 did have a mild history of accusatory behavior in her record. (Ex. 8; Testimony Burque.) However, her medical records indicate that her accusatory behavior revolved around complaints related to care, with no further record of her having falsely accused anyone of sexual abuse. (Ex. 8.)

Additional findings

30. Residents 1, 2, and 4 had BIMS scores[1] indicating no cognitive impairment. (Ex. 2.)

31. The Department of Public Health's investigation concluded that the abuse complaints were valid. (Ex. 2.)

32. Iesha Ocasio, a former co-worker of Mr. Lawrence's, submitted a statement on his behalf. She stated that she had "witnessed and experienced multiple instances involving confusion, manipulation, and false accusations. There were occasions where multiple staff members were not permitted to work alone with [Residents 1, 2, and 4] because of accusations . . . ." She also generally vouched for his character. (Ex. 10.)

33. On August 29, 2024, DPH notified Mr. Lawrence of the valid findings of abuse against him and its consequences with regard to the Nurse Aide Registry. He was also informed of his right to a hearing to dispute the charges. Mr. Lawrence filed a timely appeal. (Petitioner's request for hearing, dated October 17, 2024.)

CONCLUSION AND ORDER

Nursing home residents have the right to be free from physical and other abuse. 42 C.F.R. § 483.13(b). To keep track of allegations, findings, and adjudicated findings of abuse, neglect, and misappropriation of property, the federal government and the Commonwealth require the maintenance of a Nurse Aide Registry. 42 C.F.R. § 483.156;

[1] "The BIMS score is a quick test used in long-term care settings to check how well your brain is working. It helps caregivers track memory and thinking changes so they can give you the right support." *Cleveland Clinic, BIMS Score* (last visited May 12, 2026).

G.L. c. 111, § 72J; 105 CMR 155.016. The Registry is required to list findings[2] and adjudicated findings[3] against any person accused of patient abuse. 105 CMR 155.016(D); *see also* G.L. c. 111, § 72J. Both federal and state regulations prohibit any facility, home health agency, homemaker agency, or hospice program from hiring or employing a nurse aide if the nurse aide's name appears on the Registry. 42 C.F.R § 483.13; 105 CMR 155.10(E)(4); *see* G.L. c. 111, § 72J.

DPH alleges that Mr. Lawrence committed multiple acts of sexual abuse against five residents who were under his care at Highview of Northampton. Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, including verbal or mental abuse, or punishment with resulting physical harm, pain or mental anguish or assault and battery; provided, however, that verbal or mental abuse shall require a knowing and willful act directed at a specific person." G.L. c. 111, § 72F.

> A patient or resident has been abused if: (a) An individual has made or caused physical contact with the patient or resident in question, either through direct bodily contact or through the use of some object or substance; (b) The physical contact in question resulted in death, physical injury, pain or psychological harm to the patient or resident in question; and (c) The physical contact in question cannot be justified under [certain exceptions not applicable here].

105 CMR 155.003.

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[2] A *finding* is "the Department's determination, at the conclusion of its investigation, that an allegation of patient or resident abuse, neglect, mistreatment or misappropriation of patient or resident property against an accused is valid or not." 105 CMR 155.003.

[3] An *adjudicated finding* is "the determination of a hearing officer at the conclusion of a hearing as to whether or not a nurse aide, home health aide, or homemaker abused, neglected, or mistreated a patient or resident or misappropriated patient or resident property." 105 CMR 155.003.

DPH must prove its case by a preponderance of the evidence. *Pepin v. Div. of Fisheries and Wildlife*, 467 Mass. 210, 227 (2014), citing A.J. Cella, Administrative Law and Practice § 243 (1986).

Mr. Lawrence committed abuse against Resident 1 because he physically contacted Resident 1's breasts and genitals, causing her severe mental anguish as documented in her medical records and care plan.

The evidence that Mr. Lawrence sexually assaulted Resident 1 includes a fresh report to Mr. Asamoah; a contemporaneous written statement by the resident; statements to law enforcement, facility management, and the Department's own investigators; and medical records reflecting that she reported her trauma to her providers, they diagnosed her with that trauma, and they then adjusted her care plan to effectuate treatment.

Ms. Burque conducted a thorough investigation, and her testimony and investigation report provide a comprehensive review of the relevant material in this case. She and Mr. Asamoah agree that Resident 1 was not accusatory, she was independent-minded, she was able to change her own pull-ups, and she was continent of bowel and bladder. In other words, there was no reason Resident 1 would need to get out of bed to change a wet pull-up, and even less of a reason for her to ask her for help. Mr. Lawrence's description of the incident that took place in Resident 1's room was self-serving, changed over multiple retellings, and does not survive reasonable scrutiny.

Mr. Lawrence's defense, that Resident 1 falsely accused him, is directly contradicted by Mr. Asamoah, who treated Resident 1 for years prior to the incident and was in the best position possible to provide insight into her functional limitations and overall temperament as a resident. Mr. Asamoah's testimony about his personal knowledge of Resident 1 is consistent with how she is described throughout the medical records and testimony. Moreover, Mr. Asamoah has no reason to give inaccurate testimony, as Highview is no longer in business and he does not work with Mr. Lawrence anymore.

Mr. Lawrence's abuse of Resident 1 is an example of a pattern of abuse: Mr. Lawrence sought out female residents who suffered from both physical and mental ailments and used his position as a care provider to abuse them in the middle of the night. His abuse of Resident 2, another older and physically and mentally vulnerable resident, is another example of this pattern.

Just as he did with Resident 1, he went into her room, sexually assaulted her, then claimed that she was accusatory against the weight of all available evidence in this case. Resident 2 testified that she thought Mr. Lawrence was a kidder—until he began lifting her gown to expose her private areas, and eventually penetrated her with his finger under the subterfuge of incontinence care. As with Resident 1, Resident 2 suffered severe mental anguish, as documented in her medical records and care plan.

Mr. Lawrence's abuse of Resident 4 follows the same pattern. He ingratiated himself with her by engaging in friendly banter, until that banter turned into his remarking on her breasts and exposing himself to her. This experience caused Resident

4 mental anguish and humiliation, as reflected in her medical records. In the year-plus that transpired between the time that he exposed himself to Resident 4 and the time that she provided testimony in her deposition, her story remained essentially consistent. While Resident 4 did have a documented history of complaining about her care, there is nothing to suggest that she has ever falsely accused anyone of exposing themselves to her or any other sexual abuse.

The remainder of Mr. Lawrence's defense largely amounts to a declaration of his values and claims that he is a good person. Iesha Ocasio, a former co-worker, vouched for his character. However, like Mr. Lawrence, she shared no detailed evidence to support her opinions. Rather, she vaguely asserted in an unsworn letter that she "witnessed and experienced multiple instances involving confusion, manipulation, and false accusations" from residents and that "multiple staff members were not permitted to work alone with these individuals."

For the above-stated reasons, I conclude that Mr. Lawrence abused Residents 1, 2, and 4. Accordingly, Mr. Lawrence's name shall be placed on the Registry.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

/s/ Kenneth J. Forton

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Kenneth J. Forton
Administrative Magistrate

DATED: May 20, 2026