

**BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA,**

LOLITA WALLEN,

Petitioner,

v.

DEPARTMENT OF COMMUNITY
HEALTH, HEALTHCARE
FACILITY REGULATION,

Respondent.

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Case No.:

OSAH-DCH-HFR-NAR-1302231


31-WOODARD



OCT 25 2012

INITIAL DECISION

I. Introduction


Kevin Westray, Legal Assistant

Petitioner filed an appeal from Respondent's proposed action to place her name on the state's central nurse aide registry for committing physical abuse against a nursing home resident. An evidentiary hearing was conducted on September 13, 2012, at the Office of State Administrative Hearings (OSAH), Atlanta, Georgia. Petitioner was represented by Jewel C. Scott and John M. Turner, Jr., Attorneys at Law, Jonesboro, Georgia. Respondent was represented by Stacey Ann Hillock, Attorney at Law and Legal Services Officer, Georgia Department of Community Health, Atlanta, Georgia.

For the reasons set forth below, Respondent's determination that Petitioner committed an act of physical abuse is REVERSED.

II. Findings of Fact

1. Petitioner has been licensed as a Certified Nurses Aide (CNA) in Georgia. At the time of the incident in question, she was employed by Jonesboro Nursing and Rehabilitation Center (hereafter "nursing home" or "facility").

2. Petitioner was assigned to care for "Mrs. M", an elderly lady who suffers from post-stroke hemiparesis, and senile dementia. Mrs. M. is often difficult to understand, as her speech is garbled. She often makes herself understood by writing on a pad. She is often confused about such things as

the date and time of day. However, she is usually quite alert and observant.

3. On January 14, 2012 or January 15, 2012, Petitioner was working in Mrs. M's room along with Faye Whitfield, another CNA. Both CNAs completed their duties and left Mrs. M's room. Neither Petitioner nor Ms. Whitfield reported to their charge nurse that anything unusual occurred while they cared for Mrs. M.

4. On January 16, 2012, Janet Chaffee, Mrs. M's daughter, noticed that Mrs. M. had a bruise and discoloration on her right arm. Mrs. M. told Ms. Chaffee that someone grabbed her arm. Later, she told Ms. Chaffee and the nursing home's director of nursing that someone grabbed and twisted her arm. Mrs. M. only could identify the person as a "short female." Carolyn Marshall, LPN, and Carrie Stephens, RN and Director of Nursing, evaluated Mrs. M's injuries, and noticed that the bruising and discoloration was located on the anterior sides of her left wrist and lower arm and lower right arm. The bruising on the left arm was much larger in size.

5. Because Mrs. M. was not able to identify the individual who injured her, the nursing home identified several employees who provided her with care during shifts when it was most likely the injury occurred. These employees were then taken to Mrs. M's room. When Petitioner was brought into the room, Mrs. M. reacted by waving her arms and indicating that she did not want Petitioner to stay. Mrs. M. later confirmed that Petitioner was the person who caused her injury.

6. Petitioner was suspended by the nursing home. She later decided to resign from her position. The nursing home reported the incident to the Department of Community Health, which conducted its own independent investigation. Respondent determined that Petitioner had committed an act of physical abuse against Mrs. M. On March 19, 2012, Respondent issued a letter to Petitioner which notified her that she was guilty of physical abuse against a nursing home resident, and that a finding of abuse would be entered into the State Nurse Aide Registry.

7. Petitioner appealed this determination, and the matter was referred to the Office of State

Administrative Hearings for adjudication. No finding of abuse was entered beside Petitioner's name on the State Nurse Aide Registry while this decision was pending.

8. Current and former nursing home employees testified at the evidentiary hearing. Several employees stated that Mrs. M. is often confused and has poor short-term memory. Mrs. M. frequently objects to having others provide her care, and will flail her arms about, perhaps as a way of showing her displeasure. Mrs. M. has fragile skin, and is likely to suffer a bruise or other injury if she strikes an object while flailing her arms. Ms. Marshall testified that, in her opinion, Mrs. M. was probably injured when she flailed her arms and struck an object such as the bedside. This opinion was shared by Amy Chaney, LPN. Ms. Chaney that Mrs. M. has been prescribed blood thinners, which make Mrs. M. more likely to become bruised.

9. Most of the nursing home employees testified that Petitioner was a competent, caring, friendly, and professional-acting CNA who provided good care to her residents. These witnesses thought it would be out of character for Petitioner to intentionally or negligently cause injury to any resident.

10. Faye Whitfield, however, testified that she saw Petitioner "pop" or strike Mrs. M. on the arm or arms while they worked together in Mrs. M's room on January 14 or January 15. Ms. Whitfield did not report this to the nursing home administration until the facility had already initiated its initiation of how Mrs. M. received her injuries, which was in itself a violation of nursing home policy on reporting resident injuries. Ms. Whitfield was inconsistent in her description of where she was located when she observed the incident, on one occasion stating that she was inside Mrs. M's room, but on another occasion stating that she was in the hallway outside the room. Ms. Whitfield also changed her story about how Petitioner struck Mrs. M., and the part of Mrs. M's arm that was injured. Ms. Whitfield seemed defensive and combative when questioned about her inconsistent statements. Ms. Whitfield, who is white, blamed her failure to report the incident on the fact that she did not want to cause trouble for herself with the other employees, many of whom are black.

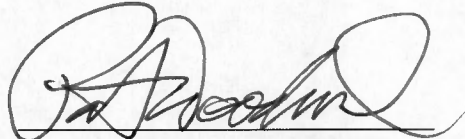
III. Conclusions of Law

1. Each state is required to have a process for the receipt, timely review, and investigation of allegations against a nurse aide of neglect, abuse, or misappropriation of resident property of those individuals who are residents of a nursing facility. 42 U.S. Code (U.S.C.) § 1396r (g) (1) (c). The Healthcare Facility Regulation Division of the Georgia Department of Community Health is the State entity responsible for the administration of this process. The federal act further requires that a nurse aide has the right to rebut any such allegations of neglect, abuse, or misappropriation of resident property, at a hearing. *Id.*
2. Federal regulations promulgated to implement 42 U.S.C. § 1396r (g)(1)(c) define "abuse" as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 Code of Federal Regulations (CFR) § 488.301.
3. Respondent has the burden of proof in this matter and the standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs., rr. 616-1-2-.07 (1) and 616-1-2-.21 (4).
4. In this case, the credible evidence produced by the nursing home's current and former employees shows that Mrs. M. suffers from senile dementia, which causes her to have poor memory, confusion, and an inability to properly identify those who gave her care. The nursing home employees testified that Petitioner was a competent CNA who treated residents well. It would be uncharacteristic of Petitioner to strike or hit a resident for any reason. Faye Whitfield, the only witness who testified that Petitioner inflicted injury on Mrs. M. produced contradictory testimony. The court finds Ms. Whitfield to be less credible than the other current and former nursing home employees who testified at the hearing.
5. In conclusion, the court finds that the injury suffered by Mrs. M. was more likely than not caused by her own actions. Mrs. M. commonly flailed her arms, which easily could have led to the bruises and discoloration she suffered on both arms.

IV. Decision

Respondent's action is REVERSED and the Respondent agency is not authorized to place its finding that the Petitioner abused a resident on the Nurse Aide Registry.

SO ORDERED, this 25th day of October, 2012.

A handwritten signature in black ink, appearing to read "M. Patrick Woodard, Jr.", written over a horizontal line.

M. PATRICK WOODARD, JR.
Administrative Law Judge