BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

ELAINE SMITH,	:	
Petitioner,	:	
	:	Docket No.:
v.	:	OSAH-DCH-NAR-1331399-60-Teate
	:	
DEPARTMENT OF COMMUNITY HEALTH,	:	
Respondent.	;	

INITIAL DECISION

I. Introduction

In response to the Department of Community Health's (DCH) determination that a finding of abuse be placed next to Elaine Smith's name on Georgia's Nurse Aide Registry, Ms. Smith requested a hearing that was held on April 16, 2013. Elaine Smith represented herself and Stacy Hillock, Esq. represented DCH. For reasons indicated, Respondent's determination on December 17, 2012 to place Elaine Smith's name on the Georgia Nurse Aide Registry for abuse is **REVERSED**.

This record is sealed to protect the name of any resident or the medical records of such a resident. Release of any documents other than this decision or the notice on the Nurse Aide Registry can occur only upon review and redaction of the record. Neither Petitioner nor Respondent is authorized to utilize any documents exchanged pursuant to this litigation without redaction of the name of any resident referenced therein.

II. Findings of Fact

Agency determination of abuse

1. DCH notified Ms. Smith of its determination of abuse on December 17, 2012. In support of that determination, DCH alleged the following:

- Ms. Smith incorrectly transferred the resident by pulling and grabbing her wrists;
- The resident was observed to have a large fresh looking purple bruise on her left wrist; and
- The incident occurred on November 15, 2012.

(Respondent Exhibit 1).

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2. After Ms. Smith clocked in for her regular night shift at 11:12 p.m., she prepared to conduct vital sign assessments for residents on her assigned hall. Larry Croker, a licensed practical nurse (LPN) works on the evening shift that overlaps Ms. Smith's night shift. He was a charge nurse and one of her supervisors at the time. He interrupted her preparation for assessments by requesting that she intervene with a resident who was walking unattended in the hallway. Ms. Smith did so and the resident yelled at Ms. Smith to leave her alone. As the resident sat down in a chair by her room's door, Ms. Smith returned to the nursing station where she could still see the resident sitting. However, Mr. Crocker instructed her to return and stand by the resident. Her exchange with Mr. Crocker became antagonistic when she asked \him if he would like for her to stand by the resident all night and Mr. Crocker responded that she should do so if necessary. The situation with the resident in the hall resolved. Ms. Smith again returned to the nurse's station to continue work on vital sign assessments. (Testimony of Elaine Smith; Respondent Exhibits 2 and 7).

3. Shortly thereafter, Petitioner noted a bathroom alarm light ringing over a room shared by EM, the resident at issue, and AW, another resident. Petitioner discovered EM, a 96 year-old female, on the toilet in her bathroom crying. Petitioner "grabbed" a brief to put on her and then "grabbed" her by her left hand and right wrist. As EM stood up, Petitioner pulled up her brief and then again "grabbed" EM's left hand and right wrist to help her walk to the bed. To accomplish this transition, Petitioner walked backward toward the bed with EM in front of her. As she did so, EM yelled and complained of pain in her arm as they walked. AW also started yelling. Petitioner allowed EM to stand on her own for a few seconds as Petitioner put her chair alarm on the bed. After Petitioner s helped EM into the bed, Larry Crocker arrived to assess the situation due to EM and another resident outside the room yelling. (Testimony of Elaine Smith; Testimony of Larry Crocker; Respondent Exhibits 2 and 7).

4. Mr. Crocker asked what was going on. Ms. Smith indicated that she was putting EM to bed. EM was crying and oddly positioned in the bed with her legs highly elevated high as if she was doing crunches. EM told Mr. Crocker that Ms. Smith had pulled her up off the toilet and thrown her into the bed by her arms. EM further was quoted to say "she was not gonna be treated this way and that big lady was mule pulling and snatching her." EM was visibly shaken and further stated "she is always rough with them" and AW nodded in agreement. Mr. Crocker observed a large red bruise less than an inch wide that went all around EM's left wrist. The skin was not broken. He had last observed her wrist at 6:00 p.m that evening and had not observed it to be bruised at that time. He went to his medical cart for Tylenol to administer to her. He then reported the matter to Lynette Smith, a registered nurse, who was in charge. (Testimony of Larry Crocker; Respondent Exhibit 6).

5. Lynette Smith confirmed Mr. Crocker's assessment and discussed the matter with Elaine Smith who requested that she be shown EM's alleged bruising. Lynette Smith showed her the bruising at issue; however, Elaine Smith denied holding EM at her left wrist. Lynette Smith suspended Elaine Smith pending investigation. She then reported the matter to Michelle Todd, the administrator. X-

rays of both EM's upper limbs were taken with no fractures indicated. (Testimony of Elaine Smith; Respondent Exhibits 5 and 7).

Investigation of the Incident and Abuse Training

6. Michelle Todd reviewed the statements of Lynette Smith, Larry Crocker and Elaine Smith that were all obtained at about 11:30 p.m. shortly after the incident and shortly before Elaine Smith was placed on suspension. She also personally interviewed Larry Crocker, Lynette Smith, EM and AW. She interviewed EM several different times. EM consistently said that "the big one" referring to Elaine Smith had "snatched her up and threw her in bed." Looking at the bruise the next day, Ms. Todd observed it to be very large and consistent with someone grabbing and holding the resident's wrist. Ms. Todd prepared a Facility Incident Report Form on November 16. She then reported to DCH on November 19 that the allegation that Ms. Smith snatched EM off the toilet by both her arms and threw her in the bed was substantiated after investigation. (Testimony of Michelle Todd; Respondent Exhibits 3, 4, 5, 6, and 7).

7. The facility provided abuse training to Elaine Smith. (Respondent Exhibit 9).

Evaluation of Witness Testimony

8. The testimony of Elaine Smith, Larry Crocker, and Michelle Todd was credible; however, the testimony of AW, EM's roommate is unreliable and therefore lacks credibility. Absent entirely leading questions poised by DCH's counsel, it is unlikely that AW could have even have identified Ms. Smith. AW is quite elderly with hearing difficulties and obvious memory impairment. (Testimony of Elaine Smith; Testimony of Larry Crocker; Testimony of Michelle Todd; and Testimony of AW).

9. EM is now deceased. She was 96 years old, frail and suffered from dementia. She previously made allegations of abuse against others that were never substantiated. Screaming was not an uncommon behavior for her. Mr. Crocker who knew her as a long-term resident observed her cognition decline though he still found her short term memory to be good. Although required assistance for daily living activities, she could do small transfers, stand and pivot. She routinely ambulated in a wheel chair and is charted to have a bed/chair alarm on her at all times. (Testimony of Elaine Smith; Testimony of Larry Crocker; Testimony of Michelle Todd; Respondent Exhibits 2).

III. Conclusions of Law

Nurse Aide Registry

1. Each state participating in the Medicaid program must establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program. 42 U.S.C. § 1396r(e)(2)(A). The registry must include "specific documented findings by a state . . . of resident neglect or abuse, or

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misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings." 42 U.S.C. § 1396r(e)(2)(B).

2. Each state is required to have a process for the receipt, timely review, and investigation of allegations against a nurse aide accused of neglect, abuse, or misappropriation of resident property of those individuals who are residents of a nursing facility. 42 U.S.C. § 1396r (g)(1)(c); 42 C.F.R. § 483.156(c)(iv). The Department of Community Health is the state entity responsible for the administration of this process and does so through its Healthcare Facility Regulation Division. 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. 42 C.F.R. § 335(c)(iii).

Investigations

3. The state must investigate every allegation of resident abuse, neglect, or misappropriation of property. Then, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut the allegations, the state must make a finding as to the accuracy of the allegations. If the state substantiates the allegation, the state must notify the nurse aide and the registry of such finding. 42 U.S.C. § 1396r(g)(1)(C); 42 C.F.R. § 488.335(a)(1) and (2). As applied, Respondent conducted an investigation and determined that Petitioner's name should be placed on the state's Nurse Aide Registry for physical abuse inasmuch as Petitioner incorrectly transferred the resident by pulling and grabbing her wrists with a resulting bruise on the left wrist.

Allegation of Abuse

4. "Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. Respondent has the burden of proof in this matter and the standard of proof is a preponderance of the evidence. Ga. R. & Regs. 616-1-2-..07 (1) and 616-1-2-.21 (4). Although Ms. Smith may have inadvertently bruised EM's wrist as she assisted her, Ms. Smith's intentions were clearly not willful. Review of the record as a whole supports a conclusion that Respondent has failed to meet its burden of proof. Ga. Comp. R. & Regs. 616-1-2-.07(1).

IV. Decision

Respondent's determination of abuse indicated in its December 17, 2012 notice to Petitioner is **REVERSED**. Accordingly, Respondent is not authorized to place Petitioner's name and its finding of abuse on the Georgia Nurse Aide Registry.

SO ORDERED, this 19th day of April 2013.

Steven W. Teate
Administrative Law Judge

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