BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

KAKELA JOHNSON, Petitioner,	:	
	:	Docket No.:
v.	:	OSAH-DCH-NAR-1334397-35-Brown
DEPARTMENT OF COMMUNITY HEALTH, Respondent.	:	

INITIAL DECISION

I. Introduction

Petitioner Kakela Johnson appeals the decision of the Department of Community Health (DCH) to enter into the State Nurse Aide Registry a finding that Petitioner neglected a resident. The hearing was held on May 17, 2013. Kakela Johnson represented herself and Stacey Hillock, Esq. represented DCH. For the reasons indicated, Respondent's decision to enter into the State Nurse Aide Registry a finding that Petitioner neglected a resident 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 neglect

1. BD is a resident of Heritage Healthcare at Sunrise (Heritage). He has a diagnosis of atrial flutter with rapid ventricular response; Type 2 diabetes; controlled, Peripheral Artery disease; chronic rheumatoid arthritis; multilevel cervical spondylosis; osteopenia; chronic back and radicular left lower extremity pain with MRI demonstrating compression of T12; and seizures. BD regularly complains of severe back and knee pain. (Respondent Exhibit 3).

2. DCH notified Petitioner of its determination of neglect on February 21, 2013. In support of that determination, DCH alleged the following:

- Petitioner was rough with the resident during care;
- The resident felt Petitioner showed no concern for his painful back stenosis;
- The resident felt intimidated by Petitioner's rough handling; and
- The incident occurred on or about October 25, 2012.

(Respondent Exhibit 1).

Incident on October 25, 2012

3. Ms. Juanita Hunter approached Petitioner and informed her that resident BD needed to use the bedside commode. Petitioner immediately went to the resident's room. Petitioner then guided BD to the stand-up lift to transfer him from his wheelchair to the bedside commode. She changed BD's pants and again used the lift to return him to his wheelchair. After assisting BD, Petitioner left the room. BD never mentioned any discomfort nor did he show any outward signs of pain while Petitioner was transferring him. Petitioner was the only person assisting BD at the time. (Testimony of Petitioner).

4. BD felt that he was handled roughly and was sitting in the hallway on October 25, 2012, when he encountered Jacqueline Hunter. Ms. Hunter is a licensed practical nurse (LPN); however, while Ms. Hunter was formerly BD's nurse, she was not assigned to him on that day. BD informed Ms. Hunter of his recent treatment, reporting that Petitioner was rough with him; that she had swung him on the lift, and that he was in pain and hurting. Ms. Hunter responded by giving BD pain medication, checking his vital signs, and notifying appropriate personnel. Afterward, she approached Petitioner regarding the incident. Petitioner denied BD's accusations. (Testimony of Petitioner; Testimony of Jacqueline Hunter; Respondent Exhibit 13).

5. After the incident, BD also told Gwendolyn Herring of his treatment by Petitioner, claiming that Petitioner was "snatching on him" when she was trying to put him in the stand-up lift. Gwendolyn Herring is a fellow Certified Nursing Assistant (CNA) who works with Petitioner. He told her that he was very upset and that he did not want her (Ms. Johnson) in his room any more. When Ms. Herring discussed the incident with Petitioner, Petitioner claimed she did not "snatch on him". (Testimony of Gwendolyn Herring; Respondent Exhibit 12).

Investigation of the Incident

6. Angela Milner is the Administrator of Heritage, and has held that position for going on three years. She is responsible for the overall management of the entire facility. She is also tasked with conducting an investigation and making reports in response to any alleged abuse or neglect. Approximately two hours after the incident, Ms. Milner noticed BD in the hallway looking upset. She approached BD and asked him what was wrong. BD replied that he was "tired of, nodding in the direction of Petitioner who was coming down the hall, being rough with him." He said it hurts

when Petitioner uses the lift. Ms. Milner then asked him if it hurts when anyone else uses the lift and he said no. (Testimony of Angela Milner; Respondent Exhibit 11).

7. Ms. Milner then called Petitioner into her office to question her about the incident. Petitioner admitted that BD complained of back pain 3 weeks earlier and that the Hoyer lift hurt him, so she reported that information to a nurse. The nurse told Petitioner to always have someone in the room with her when assisting BD after which Petitioner routinely had a witness with her. However, no witness was present during this incident. (Testimony of Angela Milner; Respondent Exhibit 3).

8. Ms. Milner also indicated that a stand-up lift requires two people to operate, as noted on the CNA Care Record. Petitioner testified that she had never seen a CNA Care Record for BD before and that everyone always uses a stand-up lift alone. Petitioner reported to Ms. Milner that no one ever told her to take another person with her to use a stand-up lift. She was aware that two people have to assist when using a Hoyer lift, but she was not aware that a stand-up lift requires two people. Petitioner also demonstrated use of the stand-up lift, specifically highlighting potential mechanical difficulties which may jostle or discomfort a resident. When questioned how she knew what care to provide, absent a review of a Care Plan, Petitioner noted that she simply followed the instructions of other CNAs and noted any special care mentioned during CNA meetings. (Testimony of Petitioner; Testimony of Angela Milner; Respondent Exhibit 9).

9. Ms. Milner reviewed the statements of resident BD, Petitioner, Alissa White, and Gwendolyn Herring, each obtained the same day of the incident. She also personally interviewed BD and attended a second interview by Social Services Director Juanita Albritten. BD consistently stated that Petitioner was rough with him and was "snatching at him" while providing assistance. Ms. Milner filed an incident report on October 26, 2012. On October 30, 2012, Ms. Milner informed Petitioner of her termination and reported to DCH that the allegation that Petitioner was rough with BD when providing assistance was substantiated after investigation. (Testimony of Angela Milner; Respondent Exhibits 2, 3, 4, 5, 6, 7, 8, 10).

10. Petitioner was astonished and concerned by the accusations. She had a good record with no complaints about her work over the course of nine years working as a CNA at various agencies and hospitals. She has never been subject to any disciplinary action. She also pointed out that the resident never made his discomfort known to her and never told her that he was ever experiencing any pain during her assistance. She could have "done something about it" if he had said anything to her. (Testimony of Petitioner).

11. Petitioner also notes that two weeks prior, resident mentioned to her and Ms. Herring that he was "looking for a wife." Both Petitioner and Ms. Herring responded that they are married. After that incident, Petitioner says it seemed that BD had it out for her. (Testimony of Petitioner; Testimony of Gwendolyn Herring).

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 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 neglect inasmuch as Petitioner was rough with the resident when operating a stand-up lift.

Allegation of Neglect

4. Neglect is defined as a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 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). The fact that the resident experienced pain does not automatically prove that there was neglect. Based on this record and the testimony of the parties/witnesses, the Respondent has failed to prove by a preponderance of the evidence that Petitioner neglected the resident. (See OSAH Rules 7 and 21)

5. Inasmuch as the Petitioner attempted to comply with her training, there has been no showing that she failed to provide a good or service necessary to avoid physical harm, mental anguish, or mental

illness. The resident experienced pain as a result of Petitioner's assistance, but pain or discomfort may occur during normal operation of a stand-up lift as demonstrated by Petitioner. Such risk of pain is exacerbated when the resident is prone to pain and virtually unavoidable if a mechanism locks up and causes an involuntary jolt. And while stand-up lifts are supposed to be operated by two people as per the CNA Care Record, Petitioner has testified that everyone operates it alone and successfully demonstrated her solo operation of the lift. 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 neglect indicated in its February 21, 2013 notice to Petitioner is **REVERSED**. Accordingly, Respondent is not authorized to place Petitioner's name and its finding of neglect on the Georgia Nurse Aide Registry.

SO ORDERED, this 17th day of June 2013.

Barbara A Brown

Barbara Brown
Administrative Law Judge