BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

CRYSTAL TURNER, Petitioner,	:	
	:	Docket No.:
v.	:	OSAH-DCH-NAR-1337177-25-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 Crystal Turner's name on Georgia's Nurse Aide Registry, Ms. Turner requested a hearing that was held on July 1, 2013. Marnique Oliver, Esq. represented Ms. Turner and Shariyf Muhammad, Esq. represented DCH. For reasons indicated, DCH's determination on January 18, 2013 to place Crystal Turner'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. Turner of its determination of abuse on January 18, 2013. In support of that determination, DCH alleged sexual and mental abuse of two residents as Ms. Turner provided incontinence care as follows:

Per the notification, the first resident reported that on November 23, 2012, Ms. Turner:

- gave her a bed bath and got very close to within one inch of her vagina;
- almost touched the resident with her mouth;
- administered the bath in such a manner that her hair was touching the resident's legs;
- responded when the resident asked what she was doing something to the effect that the

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lady in the other room likes it when I rub between her legs; and

- returned to an appropriate distance between the resident's legs when the resident indicated to Ms. Turner that it made her feel uncomfortable.

Also per the notification incident to investigation at the facility on November 23, 2012, the second resident reported that on November 21, 2012, Ms. Turner:

- touched her in the wrong way and she did not want to talk about it.
- put her hand on the resident's breast;
- rubbed the resident's leg and then the resident's breast;

The second resident responded that she reacted to Ms. Turner's actions on November 21, 2012 as follows:

- started swinging at Ms. Turner and telling her to get out;
- informing Ms. Turner that she could go to the bathroom herself and didn't need any help being changed.

(Respondent Exhibit 1).

Incident Reported by first resident

2. The first resident has resided at the facility since September 2012. She is familiar with Ms. Turner as a certified nursing assistant (CNA) who assisted her with various activities of daily living (ADL's) when her regular CNA was not available. Bathing is one such ADL that Ms. Turner had performed for the first resident numerous times before the bath on November 23, 2012. At some point during conversations occurring before November 23, Ms. Turner had asked how the first resident felt about gay people either informing the first resident that Ms. Turner's sexual orientation was gay or prompting the first resident to assume that Ms. Turner's sexual orientation was gay. The first resident declined to answer since she did not want to get into that sort of conversation with Ms. Turner. With the exception of the bath on November 23, 2012, the first resident had always gotten along with Ms. Turner and never found her prior behavior to be inappropriate. (Testimony of first resident; ??????Respondent).

3. To bathe the first resident, Ms. Turner positioned her on her back on her bed and administered the bath that required perineal care.[1] As Ms. Turner administered perineal care, the first resident

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1 Although DCH referenced perineal care, there was no evidence submitted regarding the procedure that differs for males and females. Perineal care denotes the washing of the genital and rectal areas of the body. http://wiki.answers.com/Q/How_do_nurses_give_their_patients_perineal_care Perineal care should be done at least one time a day during the bed bath, shower, or tub bath. It is done more often when a client is incontinent. Id.

From information available on the internet, the procedure for perineal care of female patients would include the

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observed Ms.Turner's head over the resident's inner thighs. Ms. Turner's hair is sufficiently long that it could touch the resident as described. It is less clear how far Ms. Turner's mouth was from the resident's vagina given the resident's lack of ability to lift her head or torso to observe Ms. Turner in that position. Clearly, the first resident was uncomfortable with Ms. Turner's bathing technique. She promptly communicated that discomfort to Ms. Turner. Ms. Turner promptly assumed a distance the resident deemed appropriate even though she commented that another resident liked to be bathed that way. (Testimony of first resident; Respondent Exhibits 2 and 7).

4. No testimony indicates the correct procedure for bathing with perineal care involved nor how Ms. Turner's care deviated from that standard beyond the first resident's perception. (Record as a whole).

5. Although the first resident felt no need to complain to the charge nurse regarding the bath, she told "Dee" and "Amy," her routine CNAs, how the bath differed from those she usually received. One of those CNA's reported the occurrence to Sarah McClarin, the Assistant Director of Nursing, who was in charge that day. (Testimony of Sarah McClaren).

Investigation of the Incident and Incident Reported by the second resident

6. Ms. McClarin notified the administrator, who is the abuse co-ordinator, and submitted an initial incident report to the state. She then attempted to call Ms. Turner who was by that time out of town until November 26. Ms. McClarin assigned the initial investigation of the matter to Corina Rewis, the social worker who was on duty on November 23 in the absence of Emily Ibanez, the Social Services Director. Ms. Rewis interviewed the first resident and other residents to whom Ms. Turner had been assigned that day. The only other complaint was from the second resident who indicated "she touched me in a wrong way. I don't want to talk about it." (Testimony of Sarah McClaren; Respondent Exhibits 4 and 5).

7. Inasmuch as Ms. Turner could not be contacted until November 26, her next scheduled work

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following:

- fill the bath basin with clean water at 110 degrees;
- position the female patient on their back;
- put a protective cover over the bed linen;
- separate the labia and wash, rinse and dry the urethral area first with short downward strokes alternating from side to side and proceeding until the exposed area around the urethra is done;
- then rinse the cloth or use a new washcloth;
- wash the groin on the outside of the labia from the front to the back starting outside the labia and then going to the inside of the thighs;
- then rinse the cloth;
- turn the person on their side;
- and wash, rinse, and dry the rectal area.

Id.

date, she was not suspended until that date. Ms. Turner denied any wrong-doing or harm to either resident. (Testimony of Sarah McClaren; Respondent Exhibit 13).

8. Upon Ms. Ibanez's return on November 26, she reviewed a statement from Nakia Williams, a CNA. On November 23, Ms. Williams reported to Ms. Rewis an incident that occurred on November 23. Ms Williams reported that she overheard the second resident telling Ms. Turner to get out of the second resident's room, stating that Ms. Turner was a man and she didn't want Ms. Turner in her room. Ms. Williams also reported Ms. Turner left the second resident's room as directed and reported the occurrence to the nurse. Heather Alvarez, a licensed practical nurse, confirmed in an interview with Ms. Ibanez on November 27 that the second resident stated Ms. Turner was a lesbian and refused to let Ms. Turner do ADL care. Ms. Alvarez further reported that when Ms. Turner reported to the charge nurse that the charge nurse requested other staff to perform the ADL care. (Testimony of Emily Ibanez; Respondent Exhibits 8 and 9)

9. On November 27, Ms. Ibanez conducted a second interview with the first resident who indicated that she felt safe in the facility since Ms. Turner was no longer around. (Testimony of Emily Ibanez; Testimony of first resident; Respondent Exhibit 10).

10. Ms. Ibanez also conducted another interview on November 27 of the second resident. Ms. Ibanez reported that the second resident indicated that Ms. Turner put her hand on my breast and that the resident started swinging and told her to get out. Ms. Ibanez also reported that the second resident told her that: (1) Ms. Turner started to rub the resident's leg and then touched the resident's breast, (2) Ms. Turner was being fresh; (3) the resident did not need help being changed, that she could go to the bathroom by herself, (4) the resident wasn't expecting it since she was a woman, and (5) Ms. Turner told the nurse it was in the resident's mind and that the resident was imagining things. Ms. Ibanez stated that the second resident also stated that she felt safe as long as she didn't see "that girl." (Testimony of Emily Ibanez; Respondent Exhibit 7).

Abuse Training, Incident Reporting, and Ms. Turner's termination

11. The facility provided abuse training to Ms. Turner. (Testimony of Sarah McClaren; Respondent Exhibit 12).

12. The facility filed a facility incident report on November 23, 2012 indicating sexual and mental abuse of the first and second resident. The report indicated no treatment was required, no physician was notified, no responsible party was notified, and that police were not notified. (Respondent Exhibit 2). On November 29, 2012, the facility issued a final report concluding that the allegations of sexual abuse were accurate, that the signs of discomfort of the two residents made it evident that Ms. Turner had acted inappropriately. The report indicated that Ms. Turner was terminated on November 28, 2012 and that company policy indicated a terminated employee is not allowed on the premises. An employee counseling notice on November 28, 2012 indicates termination based on two "resident's complaints of inappropriate behavior while providing perineal care" in violation of care

policy. A separation notice on November 28, 2012 indicates discharge for "violation of company policy." (Testimony of Emily Ibanez; Testimony of Sarah MClarren; Respondent Exhibits 3 and 15).

Incident following Ms. Turner's termination

13. For unexplained reasons, Ms. Turner returned to the facility after her termination sometime between 12 midnight and 12:30 a.m. on December 7, 2012. The first resident observed her in her doorway grinning and stating "why are you looking at me so strangely?" Ms. Turner then approached the first resident's bed and put her hand on the resident's arm. The first resident told Ms. Turner that her hand was cold and to remove it which Ms. Turner did. Shortly thereafter, Margaret, another CNA followed Ms. Turner into the room and asked her if she had clocked in. Ms. Turner responded "no" and explained that she was working elsewhere after termination. The charge nurse asked Ms. Turner to leave the facility which she did. Later in the morning at 10:09, Ms. McClarren filed an incident report with the police. Patricia Gignac, the Director of Nursing, interviewed the first resident upon her administrator's instruction when she reported the matter to the administrator and instructed Ms. McClarren to notify the police. (Testimony of first resident; Testimony of Captain James Pierce); Testimony of Patricia Gignac; Respondent Exhibit 11).

14. Captain James Pierce investigated the incident later in the day and indicated that he would attempt to locate Ms. Turner to give her a trespass warning. (Testimony of James Pierce; Respondent Exhibit 11).

Evaluation of Witness Testimony

15. The testimony of Sarah McClarren, Emily Ibanez, James Pierce and the first resident was credible. Petitioner's counsel objected to all statements attributed to witnesses who were not present at the hearing as hearsay. Such an objection was sustained to the extent of the truth of the matters asserted but overruled as to admissibility for showing conduct of the investigation that occurred. Nakia Williams, Heather Alvarez and the second resident were not present to give testimony. Although special arrangements were made to allow the second resident's testimony by telephone from the facility, she declined to do so. Respondent Exhibits 5, 7, 8, and 9 are based on the testimony of the second resident.

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 sexual and physical abuse for matters alleged.

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. Inasmuch as "sexual abuse" as alleged is not specifically defined beyond the general definition of "abuse," further analysis is necessary.

5. "Sexual abuse" in Black's Law Dictionary references the terms "abuse" and "rape" of which the latter is inapplicable in this case. Black's Law Dictionary , 7th Edition, p. 1406. The term "abuse" therein defined denotes the following:

> 1. To damage (a thing).
> 2. To depart from legal or reasonable use in dealing with (a person or a thing); misuse.
> 3. To injure (a person) physically or mentally;
> 4. In the context of child welfare, to hurt or injure (a child) by maltreatment. In most states, a finding of abuse is generally limited to maltreatment that causes or threatens to cause lasting harm to the child.

Black's Law Dictionary, 7th Edition, p. 10.

Within Georgia statutory provisions relating to the care of elderly residents and the reporting of abuse, the term "abuse" is defined as:

> "Abuse" means any intentional or grossly negligent act or series of acts or intentional or grossly negligent omission to act which causes injury to a resident, including, but not limited to, assault or battery, failure to provide treatment or care, or sexual harassment of the resident.

O.C.G.A.§ 31-8-81 (1).

No evidence establishes any willful sexual or mental abuse of the first resident in the context of the incidents on November 23. While Ms. Turner's behavior on December 7 when she returned to the facility is questionable, and may otherwise be actionable, the investigation had already ended and Ms. Turner was already terminated. If properly objected to, hearsay is not admissible as legal evidence. O.C.G.A. § 24-8-802. Petitioner's counsel timely objected to all hearsay statements. That objection was sustained as to the truth of the matters asserted, but was overruled as to the admission of documents to show agency conduct in its investigation. Accordingly, there is no admissible evidence supporting allegations regarding the second resident on November 21.

6. DCH 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 evidentiary record does not support a conclusion that Ms. Turner willfully sexually or mentally abused either of the two residents. Accordingly, DCH 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 January 18, 2013 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 16th day of July 2013.

Steven W. Teate
Administrative Law Judge

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