BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

LOIS TIERNEY,	*	
Petitioner,	*	
v.	*	**Case No.:**
	*	**OSAH-DCH-NAR-1343180-WOODARD**
DEPARTMENT OF COMMUNITY HEALTH,	*	
DIVISION OF HEALTHCARE FACILITY	*	
REGULATION,	*	
Respondent.	*	

FILED
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JUL 12 2013
Virginia Ramsey
Virginia Ramsey, Legal Assistant

INITIAL DECISION

I. Findings of Fact

The following Findings of Fact are based solely on a preponderance of the credible evidence produced at the hearing in Thomson, McDuffie County, Georgia on July 8, 2013.

1. Petitioner has been licensed as a Certified Nurse Aide (C.N.A.) for more than 35 years. She was employed by Thomson Health and Rehabilitation Center (hereafter "Thomson H & R" or 'Facility") from April 6, 2012 until she was terminated on December 28, 2012 following the incident at issue in this decision.

2. During the period of her employment at the Facility, Petitioner always worked the 11 p.m. to 7 a.m. shift in the Alzheimers wing. Among the residents routinely under her care was Mrs. "L.H.", an 87 year-old woman with a primary diagnosis of Alzheimers-related dementia. She has very poor short-term memory, and rarely can remember the names of her caregivers.

3. Mrs. L.H. has a history of frequently resisting care, and occasionally is combative with the Facility's staff. Some employees have observed Mrs. L.H. being verbally and physically aggressive to her caregivers. While Mrs. L.H. is able to move about using a wheelchair and can feed herself, she is reliant on the Facility's employees for help with almost all other activities of daily living. The C.N.A.s who provide care to Mrs. L.H. follow a specific Plan of Care, which instruct them not to retaliate against her if she becomes aggressive. Further, all C.N.A.s are trained on how to deal with Alzheimers patients, and to diffuse their aggressive or violent behavior by being non-confrontational. Leaving the room to allow the resident to calm down is the Facility's preferred method of handling such situations.

4. During her shift on December 27-28, 2012, Petitioner worked with another C.N.A., Linda Swint. Ms. Swint has been a C.N.A. since 2000. Although Petitioner and Ms. Swint provided differing accounts of the events of that evening, the evidence consistently shows that both C.N.A.s were in Mrs. L.H.'s room to change her adult diaper, clothing, and bedsheets.

5. Petitioner told Mrs. L.H. that she and Ms. Swint were going to get her up to change her diaper. Mrs. L.H. replied "Wait a Minute." Petitioner repeated that it was time to change her diaper. Again, Mrs. L.H. told her to wait. When Petitioner repeated her request a third time, Mrs. L.H. became aggressive and struck out at her. Whether Mrs. L.H. actually made contact with Petitioner is in dispute, but Mrs. L.H. clearly intended to prevent Petitioner and Ms. Swint from providing her with any care.

6. According to Ms. Swint's version of events, Petitioner then told Mrs. L.H. something like "I did not hit you, you don't hit me!" Petitioner then struck or hit Mrs. L.H. on the forearm or wrist, making a loud "slap" sound. Mrs. L.H. allowed Petitioner and Ms. Swint to finish cleaning and drying her without further incident.

7. Ms. Swint testified that she was "dumbfounded" by what she had seen Petitioner do to Mrs. L.H. Ms. Swint left Mrs. L.H.'s room and searched for the charge nurse, Brian Stewart. She reported to Mr. Stewart what she had seen and heard. Mr. Stewart examined Mrs. L.H. for any sign of injury, but found none. The incident was reported up the chain of command. Petitioner was removed from the floor and not allowed to work with any residents.

8. The Director of Nursing, Charlita. Flowers, spoke with Ms. Swint, Petitioner, and Mr. Stewart about the incident, and decided to terminate Petitioner from employment. The incident was reported to Respondent, which conducted its own investigation and determined that Petitioner had committed an act of neglect against Mrs. L.H. On February 18, 2013, Respondent notified Petitioner that a finding of neglect would be placed beside Petitioner's name on the state's central nurse aid registry.

9. Petitioner appealed, and this case was referred for adjudication to the Office of State Administrative Hearings. Respondent has not placed a finding of neglect on the central nurse aid registry during the pendency of this appeal.

10. Petitioner provided a very different version of the events of December 28, 2012. Petitioner states that she

did not strike out at or slap Mrs. L.H. Instead, she attempted to diffuse Mrs. L.H.'s anger and aggressiveness by trying to tickle Mrs. L.H. on the tummy. Both Petitioner and Ms. Swint testified that Petitioner sometimes used humor and tickling to change Mrs. L.H.'s behavior when she became angry and frustrated. This "play-fighting" had worked in the past, and Petitioner thought it might work again.

11. Petitioner and Ms. Swint have a history of clashing with each other, both on and off work. The first conflict occurred when both C.N.A.s were employed at Gibson Health and Rehab in Glascock County, Georgia. Petitioner's car was vandalized in the parking lot at Gibson Health and Rehab, and Petitioner reported the crime to the local sheriff's department, Ms. Swint was visited by deputies who had learned she might have been responsible. Ms. Swint denied any wrongdoing, and was never arrested or charged. Petitioner told Ms. Swint that she never told law enforcement or anyone else that she thought Ms. Swint was the culprit. Later, when both women were employed at Thomson Health and Rehabilitation, Petitioner and Ms. Swint again came into conflict over Ms. Swint's perception that Petitioner had abused a resident. She accused Petitioner of using a fly swatter to hit a male resident who was trying to grab Petitioner's purse. Petitioner testified that Ms. Swint's observation was incorrect, and that she had struck a table with the fly swatter in order to distract the resident from trying to take her purse. This incident was not reported to the Facility's administration, but both Petitioner and Ms. Swint showed emotional reactions when the incident was mentioned during the hearing.

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). Responsibility for maintaining this central registry in Georgia is vested in the Department of Community Health, Division of Healthcare Facilities Regulation. 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 "neglect" as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 Code of Federal Regulations (CFR) § 488.301. This definition does not require the state to prove a resident suffered an actual injury in order to sustain a finding of neglect. In the case at issue, Respondent asserts that Petitioner failed to provide goods and services when she struck Mrs. L.H., as she did not follow her training or Mrs.

L.H.'s Plan of Care.

3. Respondent bears 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. The only witness to the alleged incident of December 28, 2012 was C.N.A. Linda Swint. Ms. Swint and Petitioner have a history of poor interpersonal relations, which included Ms. Swint being investigated as a possible suspect in the vandalism of Petitioner's car. Ms. Swint later accused Petitioner of possible physical abuse of a nursing home resident. Even though this incident was never reported to the administration, it remains a contentious issue between them. These incidents lead the court to conclude that although Ms. Swint probably did not intentionally mislead either the nursing home administration or this court regarding what she observed, her judgment and perception certainly could be clouded by her feelings about Petitioner. For this reason, the court concludes that a preponderance of the evidence does not show that Petitioner failed to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness, and thus did not neglect Mrs. L.H.

IV. Decision

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

SO ORDERED, this 12th day of July, 2013.

M. PATRICK WOODARD, JR.
Administrative Law Judge