BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

JAMIEN PULLUM, Petitioner,	:	
	:	Docket No.:
v.	:	OSAH-DCH-HFR-NAR-1433322-64-Teate
DCH, HEALTHCARE FACILITY REGULATION DIVISION Respondent.	:	

INITIAL DECISION

I. Introduction

Petitioner, Jamien Pullum, (JP) appeals the decision of the Department of Community Health (DCH) to enter into the State Nurse Aide Registry a finding that he committed an act of neglect against a resident on May 22, 2013. The hearing on this matter was held via telephone conference on February 28, 2014. Petitioner represented himself and Stacey Hillock, Esq., represented DCH. For the reasons indicated herein, Respondent's decision to enter into the State Nurse Aide Registry a finding that Petitioner neglected a resident is **AFFIRMED**.

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

1. JP is licensed as a certified nurse aide (CNA). He was employed in this capacity at Calhoun Health Care Center (CHCC) from October 14, 2010 until he was terminated following the incident at issue in this decision. (Testimony of JP; Respondent Exhibits 2 and 5).

2. One of the residents routinely under JP's care was "TC," an eighty-seven-year-old male who suffers from Alzheimer's-related dementia and delusional disruptive behavior disorder. TC is dependent upon CHCC staff for all of his activities of daily living. TC's condition has left him short-tempered, irritable, and prone to aggressive behavior. He can be combative with staff, and will physically lash out at them when agitated. He also has a tendency to yell out uncontrollably at random times throughout the day, especially when awakened. All CNAs who provide care to TC are instructed to leave TC alone should he become combative or attempt to lash out at them. (Testimony of Tammy Alvia-Barrios; Testimony of Cindy Talley; Respondent Exhibit 7).

3. On May 23, 2013, Ms. Tammy Alvia-Barrios, a CNA at CHCC, approached Stacey Patterson, her Charge Nurse, and reported an incident that she had witnessed the previous morning. Ms. Alvia-Barrios reported to Ms. Patterson that, on the morning of May 22, 2013 between 9:00 and 9:15 a.m., she and Petitioner were in TC's room. As the two CNAs were going about performing routine duties, TC, who was lying nearly flat on his bed, became agitated and began to yell out as JP provided care. After changing TC's brief and covering him with a blanket, JP took a pitcher containing ice water off of TC's nightstand and began pouring water directly from the pitcher into TC's mouth as the resident yelled. TC swallowed the water and then resumed yelling, at which point JP again poured water into the resident's mouth. JP poured water into TC's mouth a third time, until water began to run out of TC's mouth and down his face and neck. JP wiped the water from TC's face and neck and then went about his normal duties. According to Ms. Alvia-Barrios, JP made no comments of any kind and did not appear agitated or angry before, during, or after the incident. (Testimony of Tammy Alvia-Barrios; Testimony of Stacey Patterson; Respondent Exhibits 2, 3, and 4).

4. Ms. Patterson promptly reported her conversation with Ms. Alvia-Barrios to Cindy Talley, RN, CHCC's Administrator. Ms. Talley considered JP's reported conduct particularly alarming not just because of the emotional harm conduct of this kind would do to a resident, but also because residents are not supposed to be given fluids while lying in a supine position, since this poses the risk that the resident could aspirate. Ms. Talley proceeded to open an investigation into the incident and submitted a Facility Incident Report Form to DCH. During the course of her investigation, Ms. Talley obtained written statements from Ms. Alvia-Barrios and JP. JP was placed on suspension pending the outcome of the investigation into the incident. (Testimony of Tammy Alvia-Barrios; Testimony of Stacey Patterson; Testimony of Cindy Talley; Respondent Exhibits 2, 3, and 4).

5. In his statement, JP reported that he had "offered [TC] some water," but averred that he had not done so with the intention of abusing TC. Rather, JP claimed that he and other staff members routinely offered TC fluids in order to alleviate the resident's fits of agitation. JP denied pouring water into TC's mouth until it overflowed and insisted that he would never harm or abuse a resident. (Respondent Exhibit 5).

6. Based on the investigation into the incident, Ms. Talley concluded that JP had committed an act of neglect and immediately terminated JP on May 30, 2013. Ms. Talley submitted a report to DCH in which it conveyed the findings of its investigation. (Testimony of Cindy Talley; Respondent Exhibit 3).

7. DCH notified JP of its determination of neglect on October 3, 2013. In the Notice of Adverse Action sent to JP, DCH alleged the following:

- An investigation conducted in conjunction with this office confirmed that you poured water in an agitated resident's mouth. Each time the resident yelled you poured water into his mouth. You kept pouring water down the resident's throat until it began running out of his mouth and down his face and neck.

- The incident occurred on or about May 22, 2013 during the first shift.

(Respondent Exhibit 1).

8. JP requested a hearing to dispute DCH's proposed action on or about November 12, 2013.

9. At the hearing of this matter, JP testified that he offered TC water, but denied pouring water into TC's mouth as alleged in the Notice of Adverse Action. He did not dispute that TC was lying on his back at the time or that such a position placed TC at risk of aspiration as described by Ms. Talley. (Testimony of JP; Testimony of Cindy Talley).

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), (2). As applied, DCH conducted an investigation and determined that JP's name should be placed on the State's Nurse Aide Registry for neglect inasmuch as JP poured water into his mouth as he lay on his back, posing the risk that he could aspirate.

Allegation of Neglect

4. "Neglect" is defined as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 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. Id. Respondent has the burden of proof in this matter and the standard of proof is a preponderance of the evidence. GA. COMP. R. & REGS. 616-1-2-.07(1), 616-1-2-.21(4). Based on this record and the testimony of the parties and witnesses, DCH has proved by a preponderance of the evidence that JP committed the act of neglect alleged in the October 3, 2013 Notice. See OSAH Rules 7 and 21.

5. Tammy Alvia-Barrios, an eye-witness, confirmed that she witnessed JP repeatedly pour water into TC's mouth while the resident was in the midst of uncontrollable yelling and lying flat on his back. Ms. Talley's testimony established that such a procedure placed TC at risk of aspiration. Such conduct constituted a failure to avoid physical harm since it created the risk that TC could suffer harm by aspirating on liquids poured directly into his open mouth while he lay on his back. JP offered no evidence to contradict or call into question Ms. Alvia-Barrios' testimony regarding her observations or Ms. Talley's testimony regarding the risk JP's conduct presented for TC. DCH's action is supported by a preponderance of the evidence.

IV. Decision

DCH's determination of neglect indicated in its October 3, 2013 notice to JP is **AFFIRMED**. Accordingly, DCH is authorized to place JP's name and its finding of neglect on the Georgia Nurse Aide Registry.

JP shall have the right to have included a written statement denying or explaining her conduct, or a brief summary of any such statement. If JP wishes to submit a written statement, he shall provide it to DCH within thirty days of his receipt of this decision. After the expiration of the one-year period from the date JP's name is added to the registry, he may petition the State to have his name removed from the registry upon a finding that JP's employment and personal history does not reflect a pattern of abusive behavior or neglect.

SO ORDERED, this 17th day of March, 2014.

Steven Teate
Administrative Law Judge