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AUG 6 2014

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

[redacted] **Petitioner,**

v.

DEPARTMENT OF HUMAN SERVICES, DIVISION OF HEALTHCARE FACILITIES REGULATION, Respondent.

Kevin Westray, Legal Assistant

Case No.:
OSAH-DCH-NAR-[redacted] Woodard

INITIAL DECISION

I. Findings of Fact

The following Findings of Fact are based solely on a preponderance of the evidence presented at the hearing held on August 1, 2014, at Roswell Health and Rehabilitation, Roswell, Fulton County, Georgia.

1. Petitioner is a 28 year-old female who has been a Certified Nursing Assistant (CNA) since August 4, 2013, following her training at Metro Medical Center. Petitioner was hired by Roswell Health and Rehabilitation ("Roswell H & R" or "Facility") on October 15, 2013. After several weeks observing other employees on their rounds, Petitioner was brought into the rotation. Petitioner was terminated from employment on November 19, 2013 following the incident at issue in this Decision. (Testimony of Petitioner; testimony of Patty McCleskey; Respondent Exhibit 13).

2. One of the residents in Petitioner's care was "D.C.," a 63 year-old male. D.C. suffered a stroke in December 2010, and has resulting hemiparesis on his left side. D.C. is an insulin-dependent diabetic, and is also in end-stage failure treated with dialysis three times per week. He was admitted to Roswell H & R in 2011. Due to his physical limitations, D.C. is totally dependent on the staff at Roswell H & R for all activities of daily living, including bathing, personal hygiene, and transfers. D.C. also has significant mental impairments, including severely impaired short and long-term memory loss. He has a history of becoming impatient when staff does not immediately respond to his calls for help. His frustration often leads him to curse and yell at the staff. (Testimony of Tina Gibson; testimony of Debra Peppard; Respondent Exhibits 4,5,10).

3. Petitioner was working the 7 a.m. to 3 p.m. shift on November 10, 2013, and assigned to the "Jasmine Place" wing at the Facility. Among the residents in Petitioner's care that day were D.C. and another resident known to the staff as "Miss Betty." At approximately 11 a.m., Petitioner was instructed by Tina Gibson, the

Charge Nurse on duty, to clean and dress D.C., who was expecting a visit that morning from his sister, Debra Peppard. According to Gibson, Petitioner told her "I will do Betty first." By this time, D.C. was yelling and cursing, and Gibson wanted D.C. taken care of first because of his impending family visit, and as he took less time to clean and dress than did Betty. After refusing to care for D.C., Petitioner went to the nurses' station and sat down. Gibson walked over to Petitioner and asked her what she was doing. Without responding to Gibson, Petitioner stood up, then walked to D.C.'s room where Gibson heard her exclaim, "I'm not going to take any bullshit from you today." Petitioner then went to Ms. Betty's room. Gibson did not state that D.C. reacted in any way to Petitioner's profanity. (Testimony of Gibson; Respondent Exhibits 4,6).

4. Gibson assigned another CNA, Marshelle Washington, to clean and dress D.C. According to Washington's written statement, Petitioner cursed at D.C. and refused to provide him with care. Washington did not write that D.C. reacted in any way to Petitioner's language. Washington failed to appear at the hearing despite Respondent's subpoena, and the administrative law judge admitted her statement to explain the course of investigation by the Facility and Respondent. (Respondent Exhibit 7).

5. Debra Peppard arrived at the Facility, and was approaching D.C.'s room when she heard him yelling for help. When she entered the room, Peppard observed that D.C. was dressed only in an adult diaper. Peppard saw a female employee come into D.C.'s room, and heard her tell him to "Shut Up." Peppard "told off" the employee, who then left the room. Peppard did not identify Petitioner at the hearing as that employee, although she was told shortly after the incident that the person was a new employee. (Testimony of Peppard; Exhibit 8).

6. Gibson told Petitioner to clock out and go home. The following day, the incident was reported to Patty McCleskey, the Facility's Risk Manager, who initiated an internal investigation. Based on her interviews with Petitioner, Peppard, Gibson, and Washington, McCleskey determined that Petitioner neglected to care for D.C. and that she committed an act or acts of verbal abuse against him. Petitioner was subsequently terminated from employment. (Testimony of McCleskey; Respondent Exhibits 3,4).

7. McCleskey submitted a Facility Incident Report Form to the Respondent, the agency that operates the state's Central Nurse Aide Registry. Respondent determined that Petitioner committed an act of verbal abuse against D.C. and neglected to provide his care. Petitioner was notified in a letter dated February 17, 2014 that these findings would be placed beside her name on the Registry. Petitioner filed a Request for Hearing, and these findings were not placed on the registry pending issuance of this Initial Decision. (Testimony of McCleskey; Respondent Exhibit 1).

8. Petitioner testified that she told Gibson she wanted to provide care for Betty first because she knew Betty had to be cleaned and dressed for an appointment. While caring for Betty, Petitioner heard D.C. yelling and cursing, and other employees told her that D.C. needed her. Petitioner testified that she asked for assistance from other employees so she could finish caring for Betty, but no one came to help. Petitioner testified that employees at Roswell H & R were not good at teamwork, and this incident was just one example of the bad relationships between staff members. Petitioner denied that she cursed D.C., or told him to shut up. Petitioner was unable to provide any reason why Gibson or Washington would lie about her actions, other than she was a new employee and perhaps was a "scapegoat" [the court's terminology] for the staff problems at the Facility. (Testimony of Petitioner; Respondent Exhibit 2).

II. 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.C. § 1396r (g)(1)(c). The Healthcare Facilities Regulation Division of the Georgia Department of Community Health is the State entity responsible for the administration of this process. 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. Respondent has the burden of proof in this matter and the standard of proof is a preponderance of the evidence. Ga. R. & regs., rr. 616-1-2-..07 (1) and 616-1-2-.21 (4).

3. Federal regulations promulgated to implement 42 U.S.C. § 1396r (g)(1)(c) define "abuse" of a nursing facility resident as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 42 C.F.R. § 488.301. "Neglect" is defined 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. There is no requirement that physical harm, mental anguish, or mental illness actually resulted from an aide's acts or omissions for a finding of neglect to be confirmed.

4. The administrative law judge concludes that the evidence produced from Gibson and Washington is unbiased and credible. The testimony presented by Petitioner is self-serving, and contradicts the unbiased statements of two eyewitnesses. Therefore, the administrative law judge concludes Petitioner's testimony is not credible.

5. Petitioner used profanity and harsh language in D.C.'s presence which can be construed as verbal intimidation. However, there is no evidence that her statements caused D.C. to react in any way that would indicate he suffered physical harm, pain, or mental anguish. For this reason, the administrative law judge cannot conclude that Petitioner committed an act of abuse against D.C.

6. Petitioner refused to follow Gibson's instructions to provide care to D.C., and instead cared for another resident. D.C. continued to yell and curse because he was not getting cleaned and dressed, services he is not physically capable of providing for himself. There is no legal requirement that neglect cause actual harm to a resident for the allegation to be confirmed. Therefore, the evidence proves that Petitioner committed neglect against D.C.

III. Decision

Petitioner committed an act of neglect against a nursing home resident, and that finding may be placed against her name on the Central Nurse Aid Registry. However, Petitioner's actions do not meet the definition of "abuse" and no such finding may be placed on the Central Nurse Aid Registry. Therefore, Respondent's action is **AFFIRMED IN PART, AND REVERSED IN PART.**

SO ORDERED, this 6th day of August, 2014.

M. PATRICK WOODARD, JR.
Administrative Law Judge