BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

MARY JO LAWSON,	:	
Petitioner,	:	
	:	
v.	:	**Docket No.:**
	:	**OSAH-DCH-HFR-NAR-1551508-33-Woodard**
DCH, HEALTHCARE FACILITY	:	
REGULATION DIVISION	:	
Respondent.	:	

INITIAL DECISION

I. Introduction

Petitioner Mary Jo Lawson appeals the decision of the Department of Community Health, Healthcare Facility Regulation Division (hereinafter "DCH" or "Respondent") to enter into the State Nurse Aide Registry a finding that she misappropriated the property of a nursing home resident. The hearing on this matter was held on June 4, 2015 at Powder Springs Nursing & Rehabilitation, Cobb County, Georgia, before the undersigned Administrative Law Judge of the Office of State Administrative Hearings (OSAH). Ms. Lawson represented herself at the hearing and Ms. Stacey Hillock, Esq., represented DCH.

For the reasons indicated herein, Respondent's decision to enter into the State Nurse Aide Registry a finding that Ms. Lawson misappropriated the property of 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. Ms. Lawson is a Certified Nurse Aide ("CNA"). She worked in this capacity for Powder Springs Nursing & Rehabilitation (hereinafter "Powder Springs"), a skilled nursing and short-term rehabilitation facility, beginning in February 2013, until she was terminated following the incident at issue in this Decision. (Respondent's Exhibit 11; Testimony of Mary Jo Lawson; Testimony of Donna Meredith).

2. Ms. Lawson was assigned to work in Powder Springs' Memory Care Unit, a thirty-four-bed secured unit for residents who are in the "wandering stage" of Alzheimer's disease. During a typical shift, the Memory Care Unit was staffed by three CNAs and two LPNs. Ms. Lawson

typically worked the Memory Care Unit during the 7:00 a.m. to 3:00 p.m. shift. (Testimony of Donna Meredith).

3. One of the residents in Powder Springs' Memory Care Unit was "TD", a seventy-eight year old male. TD was a total care patient with a primary diagnosis of Alzheimer's dementia. Due to severe cognitive and functional deficits caused by his illness, TD was incapable of independently performing activities of daily living or making his needs known to his caregivers. (Exhibits R-3, R-4, R-10; Testimony of Donna Meredith; Testimony of Umma Abubakar).

4. TD's medications included Buspar, an anti-anxiety medication. Buspar was delivered by a pharmacy located in Smyrna, Georgia to the facility in 10mg tablets. Because TD was incapable of taking the medication in pill form, the Buspar tablets had to be placed in a clear plastic pouch and crushed into powdered form using a "Silent Knight" crushing device. The resulting powder was stirred into TD's food. (Testimony of Umma Abubakar; Testimony of Donna Meredith)

5. Powder Springs orders refills for TD and other residents directly from the pharmacy. A courier service picks up the medications from the pharmacy and delivers them to Powder Springs twice per day at 1:00 p.m. and midnight. The courier carries the prescription medications, which are packaged in a tote, inside the facility and hand-delivers them to a facility staff member. A nurse from the Memory Care Unit thereafter retrieves the residents' medications and returns them to the unit. (Testimony of Donna Meredith).

6. Once the medications are inside the Memory Care Unit, they are placed into one of two "medcarts" under a tab with the resident's name. Both medcarts are kept locked when not in use. Each of the Memory Care Unit's LPNs carries keys to the medcarts, which are kept on keyrings. Because these keyrings also have keys to other parts of the building, including the shower room and the "refrigerator room," where the unit stores employees' food and drinks, LPNs will provide these keyrings to CNAs at their request. (Testimony of Umma Abubakar; Testimony of Donna Meredith; Testimony of Nancy Griffith).

7. On November 21, 2014 at approximately 1:00 p.m., Ms. Donna Meredith, Director of Nursing at Powder Springs, received a phone call from Johnny Darrell McEachin, who identified himself as Ms. Lawson's boyfriend. Mr. McEachin reported that Ms. Lawson had stolen a resident's medications and brought them home for him to take. Mr. McEachin identified the medication as Buspar, described it as a "nerve pill," and recited the lot number, expiration date, and manufacturer number. According to Mr. McEachin, an LPN had given the medication to Ms. Lawson to give to him. At Ms. Meredith's request, Mr. McEachin agreed to travel to the facility with the medication. (Exhibit R-3; Testimony of Donna Meredith)

8. Mr. McEachin presented Ms. Meredith with a small plastic pouch containing twenty 10mg tablets of Buspar. The pouch was identical to those used to crush the residents' medications and was marked "Silent Knight." A sticker affixed to the front of the pouch bore a bar code, a manufacturer's name, a lot number, and an expiration date. (Exhibits R-3, R-13, R-14; Testimony of Donna Meredith).

9. Ms. Meredith notified police, filed a preliminary incident report with DCH, and commenced an internal investigation into the incident. Ms. Meredith interviewed Ms. Lawson, who stated that she "had no idea" how TD's medication came to be in Mr. McEachin's possession. Ms. Lawson denied giving Mr. McEachin the medication and claimed that he was trying to "set her up," explaining that the two were involved in an ongoing personal dispute. Ms. Meredith obtained Ms. Lawson's written statement and informed her that she would be placed on suspension pending the outcome of the investigation. (Exhibit R-5; Testimony of Donna Meredith).

10. Ms. Meredith directed Nancy Griffith, Nurse Supervisor, to investigate whether TD's Buspar was missing from the Memory Care Unit's medcarts. Ms. Griffith determined that TD was the only patient in the unit who took Buspar. In comparing the bubble packs of TD's medications with the medication record, Ms. Griffith determined that approximately twenty Buspar tablets were missing and unaccounted for. (Exhibit R-3; Testimony of Nancy Griffith).

11. Tomeka Davis, Assistant Director of Nursing at Powder Springs, conducted interviews of Umma Abubakar, LPN, and Chantel Fombi, LPN, the two nurses assigned to the Memory Care Unit during Ms. Lawson's shift. Both nurses denied giving TD's medication to Ms. Lawson or having knowledge of how TD's medication could have left the Memory Care Unit. (Exhibit R-8; Testimony of Tomeka Davis).

12. Further investigation revealed that the bar code, manufacturer's name, lot number, and expiration date on the sticker affixed to the pouch returned to the facility by Mr. McEachin was identical to the information contained on bubble packs of Buspar belonging to TD. Mr. Scott Holloway, Powder Springs' administrator, later called the pharmacy and confirmed that the medication had been among those delivered to Powder Springs at an earlier date. (Exhibit R-3; Testimony of Nancy Griffith; Testimony of Scott Holloway; Testimony of Donna Meredith).

13. On November 24, 2014 at approximately 7:00 a.m., Mr. McEachin returned to Powder Springs and spoke with Ms. Meredith and Mr. Holloway and indicated that he wished to recant his earlier statements regarding how TD's medication came to be in his possession. He stated that, contrary to his earlier report, Ms. Lawson had not given him the Buspar, and that he had fabricated the allegation in order to get Ms. Lawson "into trouble." According to Mr. McEachin, he acquired the medication from Powder Springs' parking lot, after they fell from the pocket of a lab coat carried by one of the facilities' nurses. Mr. McEachin stated that he retrieved the pouch from the ground and kept it in the console of his truck, where it remained until he returned it to Powder Springs on the day of the incident. Mr. McEachin could not identify the nurse who reportedly dropped the pouch and described her only as "a little colored girl." During this encounter with Mr. McEachin, Ms. Meredith observed that he appeared "anxious" and "a little upset." Ms. Meredith wrote out Mr. McEachin's statement and obtained his signature. (Exhibit R-7; Testimony of Donna Meredith; Testimony of Scott Holloway; Testimony of Johnny Darrell McEachin)

14. Based upon the findings of the investigation, Ms. Meredith concluded that Mr. McEachin's initial version of how he obtained the Buspar was truthful, and that Ms. Lawson had misappropriated the property of a resident. Ms. Lawson was terminated from employment at Powder Springs on November 26, 2014. As required by law, Ms. Meredith then referred the matter to the Department of Community Health. (Exhibit R-11).

15. In a letter dated February 10, 2015, DCH notified Ms. Lawson of its intent to place a finding that she had misappropriated a resident's property on the State Nurse Aide Registry. Ms. Lawson appealed DCH's determination on or about February 25, 2015 and the case was referred to the Office of State Administrative Hearings for adjudication. (Exhibits R-1, R-5).

16. At the hearing on June 4, 2015, Ms. Lawson again denied that she had misappropriated TD's medications. She testified that Mr. McEachin fabricated his accusations out of spite because she had asked him to leave her home the previous week. She could not account for how TD's medication came to be in Mr. McEachin's possession. Ms. Lawson testified that Mr. McEachin has a diagnosis of Bipolar Disorder, for which he takes multiple medications. (Testimony of Mary Jo Lawson).

17. Mr. McEachin testified that he had acquired the Buspar under the circumstances described in his November 24, 2014 written statement, in which he attempted to recant the version of events described to the facility's administration on November 21, 2014. According to Mr. McEachin, he had been sitting in his truck in Powder Springs' parking lot, waiting for Ms. Lawson to exit the facility, when he observed a short, black woman exiting the facility with a white lab coat draped over her left arm. Mr. McEachin testified that the woman failed to notice as the pouch of pills fell from the pocket of the lab coat and onto the ground, whereupon he retrieved them and placed them in the console of his truck. He claimed that he fabricated his initial report that Ms. Lawson had misappropriated the medication because he was enraged at Ms. Lawson and "wanted to hurt her." Mr. McEachin acknowledged that he took several medications to treat his Bipolar Disorder, though he could not recall whether he had ever been prescribed Buspar, and testified that Ms. Lawson paid for his prescriptions while they were together. (Testimony of Johnny Darrell McEachin).

III. Conclusions of Law

1. DCH has the burden of proof in this matter. Ga. Comp. R. & Regs. 616-1-2-.07(1) (2015). The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21(4) (2015).

Nurse Aide Registry

2. 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) (2014). 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) (2014).

3. 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) (2014). 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) (2014).

Investigations

4. 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 asserts that a finding of misappropriation of resident property should be placed next to Ms. Lawson's name in the State Nurse Aide Registry because an investigation conducted with Powder Springs concluded that she had stolen the medication of TD, a resident.

Misappropriation of Resident Property

1. "Misappropriation of resident property" is defined as "the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." 42 C.F.R. § 488.301. In the present case, DCH proved, by a preponderance of the evidence, that Ms. Lawson misappropriated resident property.

2. That the medication belonged to TD and originated from the Memory Care Unit is beyond dispute. Unique identifying information on medication packaging maintained for TD in the Memory Care Unit—including the bar code and lot number—precisely matched the information on the pouch returned to the facility by Mr. McEachin. Moreover, an audit conducted by the facility revealed that TD, the only resident in the Memory Care Unit prescribed Buspar, was missing approximately twenty 10mg tablets of the medication.

3. Mr. McEachin offered two explanations as to how he gained possession of TD's medication. Initially, he reported that Ms. Lawson had stolen the medication from the memory care unit and given it to him. He thereafter recanted and claimed to have acquired the medication when a nurse, whom he could not identify, inexplicably (and illegally) carried the medication—which, coincidentally, belonged to a resident of the Memory Care Unit where Ms. Lawson worked—from the facility, and dropped it in the parking lot without noticing, thereby allowing him to

retrieve it. The Court finds the initial scenario proffered by Mr. McEachin much more plausible. See, e.g., Holiday v. State, 272 Ga. 779, 780-81 (2000) ("[P]rior statements are made closer in time to the event when memories are fresher and when there is 'less likelihood that the statement is the product of corruption, false suggestion, intimidation or appeals to sympathy.'") (quoting State v. Whelan, 513 A.2d 86, 91 (Conn. 1986)). Accordingly, DCH is authorized to place a finding that Ms. Lawson misappropriated the property of a resident next to her name on the State Nurse Aide Registry.

IV. Decision

In accordance with the foregoing Findings of Fact and Conclusions of Law, DCH's decision to place Ms. Lawson's name, a finding misappropriation of resident property, and a written description of the incident on the State Nurse Aide Registry is hereby **AFFIRMED**.

SO ORDERED, this 1st day of July, 2015.

M. PATRICK WOODARD
Administrative Law Judge