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Kevin Westray, Legal Assistant

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

VIRGINIA CHAMBERS,	:	
Petitioner,	:	
	:	
v.	:	**Docket No.:**
	:	**OSAH-DCH-HFR-NAR-1615989-64-Brown**
DCH, HEALTHCARE FACILITY	:	
REGULATION DIVISION	:	
Respondent.	:	

INITIAL DECISION

I. Introduction

Petitioner Virginia Chambers 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 abused a nursing home resident. The hearing on this matter was held before the undersigned Administrative Law Judge at Gordon Health & Rehabilitation on November 23, 2015. Ms. Chambers represented herself at the hearing 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 Ms. Chambers abused a nursing home resident is **REVERSED**.

This record is sealed to protect the name of any resident(s) or the medical records of such resident(s). 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. Chambers is a Certified Nurse Aide ("CNA"). She worked in this capacity for Gordon Health & Rehabilitation (hereinafter Gordon Health & Rehab), a skilled nursing facility, from September 18, 2012 to May 12, 2015. Ms. Chambers worked at the facility during the 3:00 p.m. – 11:00 p.m. shift ("second shift"). (Exhibits R-4, R-14; Testimony of Michelle Fox; Testimony of Dawn Davis; Testimony of Virginia Chambers).

2. One of the residents routinely under Ms. Chambers' care at Gordon Health & Rehab was "MP", an eighty-two-year-old female admitted to the facility on April 17, 2012. MP's diagnoses included hypertension, GERD, interverbral disc disorder, osteoarthritis, anemia, depression, anxiety, and dementia. Despite her diagnosis of dementia, MP was alert and oriented times three, and was capable of making her needs known. Due to functional deficits caused by her

diagnoses, she required the assistance of the facility's staff members to complete all activities of daily living. (Exhibit R-4; Testimony of Dawn Davis; Testimony of Michelle Fox).

3. On May 5, 2015, Robin Stallings, Resident Care Coordinator at Gordon Health & Rehab, received a report from a CNA concerning a complaint by MP against Ms. Chambers. According to the CNA, MP complained that Ms. Chambers had refused to put her to bed at her request, and made her stay up until 8:00 p.m. Based on the resident's complaint, Ms. Stallings held a counseling session with Ms. Chambers. During this counseling session, Ms. Stallings informed Ms. Chambers of MP's complaint, and directed her to put residents to bed at their request. Ms. Chambers denied that she had refused to put MP to bed at her request. (Exhibits R-3, R-4, R-8; Testimony of Robin Stallings).

4. The following day, May 6, 2015, Darlene Arguello, CNA, was assisting with transferring MP in the shower room when MP reported to her that Ms. Chambers had entered her room the previous day and confronted her regarding the above-described complaint. Specifically, MP alleged that Ms. Chambers entered her room and said to her: "You got me in trouble." MP further reported that, when she denied Ms. Chambers' accusation, Ms. Chambers replied "Well you told someone some stuff on me and I don't like people telling lies on me." Another CNA, Shawn Goforth, was assisting another resident in the shower room and overheard MP's account. (Exhibits R-4, R-5, R-6; Testimony of Darlene Arguello; Testimony of Shawn Goforth).

5. Ms. Arguello and Ms. Goforth notified Michelle Fox, Social Services Director at Gordon Health & Rehab, of MP's allegations against Ms. Chambers. Ms. Fox thereupon interviewed MP, who repeated her account of the alleged incident. (Exhibits R-4, R-5, R-7; Testimony of Michelle Fox; Testimony of Shawn Goforth; Testimony of Darlene Arguello).

6. Ms. Fox filed an initial incident report with DCH. Based on MP's account, Ms. Fox and Dawn Davis, Gordon Health & Rehab's Director of Nursing, commenced an investigation into the incident. During the course of this investigation, they collected statements from Shawn Goforth, Darlene Arguello, Robin Stallings, Virginia Chambers, and Johanna Calhoun, a CNA who worked first shift at Gordon Health & Rehab. (Exhibits R-3 to -10; Testimony of Michelle Fox; Testimony of Dawn Davis).

7. In her statement, Ms. Calhoun indicated that "KS", another resident under Ms. Chambers' care, reported to her that, on one occasion, Ms. Chambers told her that if she was not ready to go to bed at the start of second shift, she would have to wait until later, and made the resident wait until 9:30 p.m. to go to bed. (Exhibit R-9; Testimony of Johanna Calhoun).

8. During the investigation, Ms. Fox also obtained the statement of "AG", another resident of Gordon Health & Rehab under Ms. Chambers' care. AG indicated that Ms. Chambers' demeanor altered depending on whether residents were in bed at the start of second shift. Specifically, AG reported that Ms. Chambers would walk the hall at the start of the shift, and if she determined that most residents had already been put to bed, she would be in a pleasant mood. However, according to AG, if most residents were not in bed, "everybody ha[d] a bad day."

(Exhibit R-7).

9. Neither AG nor KS witnessed or had personal knowledge of the alleged incident involving MP and Ms. Chambers. (Exhibits R-4, R-7, R-9; Testimony of AG; Testimony of KS).

10. Based on the findings of the investigation, Ms. Davis concluded that the allegation of verbal abuse against Ms. Chambers was substantiated. On May 12, 2015, Gordon Health & Rehab terminated Ms. Chambers' employment and conveyed the findings of its investigation to DCH in a final incident report. (Exhibits R-4, R-14; Testimony of Dawn Davis).

11. In a letter dated July 27, 2015, DCH notified Ms. Chambers of its intent to place her name, a written description of the incident, and any written statement that she may wish to make denying or explaining her conduct on the State Nurse Aide Registry. This letter provided as follows:

> An investigation conducted in conjunction with this office confirmed that you willfully intimidated a resident by confronting her in an accusatory manor [sic] after being verbally reprimanded for disregarding resident rights by not assisting three residents to bed when they desired to go to bed. This incident occurred on or about May 5, 2015.

The adverse action letter sent to Ms. Chambers does not allege that she committed misconduct by failing to put residents to bed at their request. (Exhibit R-1).

12. Ms. Chambers subsequently appealed DCH's determination and the matter was referred to the Office of State Administrative Hearings for adjudication. (Exhibit R-2).

13. During her testimony at the evidentiary hearing, MP recalled an incident in May 2015 during which a CNA had "slapped her around" and angrily accused MP of getting her "in trouble." However, when asked to visually identify Ms. Chambers, who was present at the hearing, as the offending CNA, MP said: "That's Virginia Chambers? . . . It wasn't her. That ain't the one." According to MP, the CNA who committed the alleged act of verbal abuse was, like Ms. Chambers, black, but "did not look like her" and was not present at the hearing. MP testified that she "always liked" Ms. Chambers. MP made the foregoing statements without hesitation or the slightest indication that she was intimidated by Ms. Chambers. There is nothing in the evidentiary record to suggest that MP's cognitive functioning has declined since her initial report of verbal abuse. (Testimony of MP).

14. Contrary to what was written in her statement, AG testified that Ms. Chambers' "was friendly" regardless of whether most residents were in bed by the start of second shift. AG further testified that Ms. Chambers never refused to put her to bed, but that she sometimes would have to wait her turn. AG is alert and oriented times three and suffers from no cognitive deficits. (Testimony of AG; Testimony of Michelle Fox; Testimony of Dawn Davis).

15. KS testified that, on one occasion, Ms. Chambers asked her at the start of second shift if she

was ready for bed, and told her that if she was not ready to go to bed at that time, she would have to wait until later. She conceded that she could not recall the incident with specificity because she was "not with it" at the time owing to her medications. She further testified that Ms. Chambers "always did a good job" and that she never refused to put her to bed. (Testimony of KS).

III. Conclusions of Law

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

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). 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).

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). 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. § 488.335(c)(iii).

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).

Allegations of Abuse

5. "Abuse is defined 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.

6. Having carefully reviewed the evidentiary record, the undersigned concludes that DCH did not have sufficient proof to support its finding that Ms. Chambers was verbally abusive toward MP.

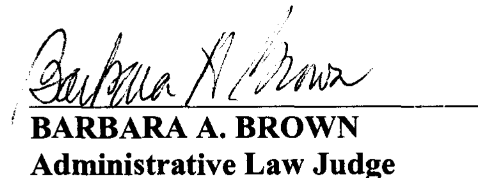
MP, the only eyewitness to the alleged verbal abuse, testified upon seeing Ms. Chambers that she was not the CNA who verbally abused her. MP's unequivocal testimony that Ms. Chambers was not the CNA who committed the act of abuse calls her earlier statements into question, and renders them insufficient to support the finding of abuse.

7. DCH did not cite Ms. Chambers' alleged failure to assist residents into bed as misconduct for which it sought to place her name on the Nurse Aide Registry. Due process mandates that the review of this tribunal be limited to a determination of whether Ms. Chambers engaged in the misconduct expressly described in the notification of adverse action provided to her. See, e.g., Lankford v. Idaho, 500 U.S. 110, 126 (1991); Mullane v. Central Hanover Bank & Trust Co., 339 U.S. 306, 314 (1950) (notice must be "reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections"); see also 42 C.F.R. § 488.335(c)(3)(i) ("The notice must include the . . . [n]ature of the allegation(s)[.]"). However, even if the undersigned were to consider allegations that were not cited in the adverse action letter, DCH failed to demonstrate that Ms. Chambers engaged in the alleged misconduct. AG and KS testified that, while Ms. Chambers may not have always been prompt in assisting them into bed, she never refused to provide assistance, and certainly did not engage in conduct that would meet the definition of neglect. See 42 C.F.R. § 488.301.

IV. Decision

In accordance with the foregoing Findings of Fact and Conclusions of Law, DCH's decision to place a finding of abuse next to Ms. Chambers' name on the State Nurse Aide Registry is hereby **REVERSED.**

SO ORDERED, this 11th day of January, 2016.



BARBARA A. BROWN
Administrative Law Judge