BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

KATHLEEN MAIR, Petitioner,	:	
v.	:	Docket No.: OSAH-DCH-HFR-NAR-1627980-147-Teate
DCH, HEALTHCARE FACILITY REGULATION DIVISION Respondent.	:	

INITIAL DECISION

I. Introduction

Petitioner Kathleen Mair 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 Park Place Nursing & Rehab in Monroe, Georgia, on February 12, 2016. E.W. Wyman, Esq., represented Ms. Mair at the hearing and Shariyf Muhammad, Esq., represented DCH. For the reasons indicated herein, Respondent's decision to enter into the State Nurse Aide Registry a finding that Ms. Mair 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. Mair has been a Certified Nurse Aide ("CNA") for approximately thirty years. She worked in this capacity for Park Place Nursing & Rehab (hereinafter "Park Place"), a skilled nursing facility, from January 19, 2013 to July 8, 2015, on which date she was terminated following the incident at issue in this Decision. Prior to her termination from Park Place, Ms. Mair had never been subject to disciplinary action for conduct involving abuse, neglect, or misappropriation of property. (Respondent's Exhibit 14; Testimony of Kathleen Mair).

2. Ms. Mair worked at Park Place during the day shift. One of the residents routinely in her care at the facility was "WW", a sixty-eight-year-old female admitted to the facility on June 27, 2014. WW was able to communicate her needs, but experienced confusion and disorientation at times. She also required limited assistance with hygiene and mobility. (Respondent's Exhibits 4, 9;

Testimony of Lisa Niedling; Testimony of Lorna Cosenza).

3. On July 8, 2015 at approximately 11:00a.m., Ms. Mair approached Lisa Niedling, Charge Nurse, and Lorna Cosenza, Unit Supervisor, and reported that she had struck WW. Specifically, Ms. Mair reported that, while she was in WW's room administering care, WW slapped her across the face, to which Ms. Mair reacted by slapping the resident. Ms. Mair was very remorseful, and indicated that she did not mean to hit WW, but that she did so according to "an instant reflex." Ms. Niedling testified at the hearing on this matter that Ms. Mair appeared "upset" and "a little frantic" at the time she made the report. (Respondent's Exhibits 4, 5, 6; Testimony of Lisa Niedling; Testimony of Lorna Cosenza).

4. Ms. Cosenza and Ms. Niedling entered WW's room and approached the resident, who was sitting in her wheelchair. WW, who was visibly upset and crying, reported to the two nurses that Ms. Mair had "told her to hit her," that Ms. Mair was "trying to rule her," and that Ms. Mair threatened to report WW to WW's boyfriend. Ms. Cosenza and Ms. Niedling noted redness on the left side of WW's face and finger marks on her left temple. (Respondent's Exhibits 4, 5, 6, 7; Testimony of Lisa Niedling; Testimony of Lorna Cosenza).

5. After Michelle Hayes, Park Place's Clinical Administrator, was alerted to the incident, she, Ms. Niedling, Ms. Cosenza, and Park Place's Administrator, Ken Murray, met with Ms. Mair. During this meeting, Ms. Mair again admitted that she struck WW, and explained that "it was an immediate reflex to slap her back without thinking." (Respondent's Exhibit 8; Testimony of Michelle Hayes; Testimony of Ken Murray).

6. Based upon Ms. Mair's admission that she struck a resident, Park Place immediately terminated her from employment. Park Place also alerted the Walton County Sheriff's Office[1] and filed an initial incident report with DCH. (Respondent's Exhibit 3, 4, 5, 8, 14).

7. In a letter dated November 16, 2015, DCH notified Ms. Mair 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, in part, as follows:

> An investigation conducted in conjunction with this office and the Walton County Sheriff's Department[] confirmed that you willfully intimidated and physically abused a resident by telling her that you would report the resident to your boyfriend to get the resident in trouble and slapped the resident across the left side of her face resulting in redness and finger marks across her temple. Your actions left the resident crying and scared. This incident occurred on or about July 8, 2015.

[1] From the evidentiary record, it does not appear that criminal charges were filed against Ms. Mair as a result of the incident.

(Respondent's Exhibit 1).

8. Ms. Mair appealed DCH's determination on or about November 30, 2015, whereupon the matter was referred to the Office of State Administrative Hearings for adjudication. In her written appeal, Ms. Mair indicated that she made contact with WW after the resident slapped her only to restrain the resident from striking her a second time. (Respondent's Exhibit 2).

9. In her testimony, Ms. Mair denied intentionally striking WW in the face. She testified that, after the WW slapped her, she grabbed the resident's hand and instinctively pushed it back toward the resident's face in order to defend herself from further attack. (Testimony of Kathleen Mair).

10. Yvonne McBean, LPN, formerly worked with Ms. Mair at nursing facilities in New Jersey and Georgia. She opined in her testimony that Ms. Mair provided "above average" care as a CNA, and that abusing nursing home residents was not in her character. (Testimony of Yvonne McBean).

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 (emphasis added). In order for an individual to have perpetrated abuse such as to justify the placement of his or her name on the Nurse Aide Registry, the individual must have acted *willfully*. Salmon v. Dep't of Pub. Health & Addiction Servs., 788 A.2d 1199, 1211 (Conn. 2002). An individual acts willfully where he or she makes "*a conscious decision* to do the act which the law forbids." Hearns v. District of Columbia Dep't of Consumer & Regulatory Affairs, 704 A.2d 1181 (D.C. 1997) (emphasis added); see also BLACK'S LAW DICTIONARY 1737 (9th ed. 2009) (defining "willful" as "Voluntary and intentional, but not necessarily malicious."). In other words, the individual's conduct is willful where it is "voluntary, rather than accidental or inadvertent." Salmon, 788 A.2d at 1212 (Conn. 2002); see also Screws v. United States, 325 U.S. 91, 101 (1945).

6. Having carefully reviewed the evidentiary record, the undersigned concludes that DCH has failed to support its finding that Ms. Mair abused WW. The evidence on record does not show that Ms. Mair's infliction of injury upon WW was "willful," as is required to merit a finding of abuse, but rather an instantaneous and reflexive act of self-defense. Immediately after the incident, Ms. Mair reported that she struck WW, but that she did so unintentionally and as "an instant reflex." Nothing in the record contradicts Ms. Mair's claim that she acted out of reflex. Reflexive conduct is, by definition, not conscious, willful behavior. See, e.g. WEBSTER'S ENCYCLOPEDIC UNABRIDGED DICTIONARY OF THE ENGLISH LANGUAGE (1996) (defining "reflex" as "noting or pertaining to an involuntary response to a stimulus . . ."); see also Rucci v. State Dep't of Children & Families, No. CV020516990S, 2003 Conn. Super. LEXIS 3194, at *14–15 (Conn. Super. Ct. Nov. 5, 2003) (holding that a hearing officer's conclusion that action was "reflexive" contradicted his finding that such action was "intentional") (citing Salmon, 788 A.2d at 1199); Baker v. 221 N. 9 St. Corp., No. 08-CV-03486 (KAM) (MDG), 2010 U.S. Dist. LEXIS 99915, *18–20 (E.D.N.Y. Sept. 23, 2010) ("a 'reflexive' act is always unintentional . . ."). Accordingly, inasmuch as the evidence shows that Ms. Mair acted reflexively, and not willfully, the undersigned concludes that she did not abuse a nursing home resident. See Kling v. Birchwood Health Care Ctr. No. CX-89-1121, 1989 Minn. App. LEXIS 1128, *3–4 (Minn. Ct. App. Oct. 12, 1989) (holding that nursing assistant's slapping of a resident in response to resident's own aggression did not rise to the level of misconduct because the nursing assistant's conduct was a "reflex reaction . . . and was not intentional or voluntary").

7. DCH's finding that Ms. Mair "willfully intimidated [WW] . . . by telling her that [she] would report the resident to [her] boyfriend" is without evidentiary support. It appears that the only evidence for this finding is the hearsay statement of WW, which is of negligible value absent the sworn testimony of the declarant. See, e.g., Chambers v. Miss., 410 U.S. 284, 298 (1973).

Moreover, the credibility of WW's accusation is questionable, considering that WW is prone to confusion, and her remarks were accompanied by even more implausible accusation that Ms. Mair directed WW to hit her because she wanted to "rule" WW.

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. Mair's name on the State Nurse Aide Registry is hereby **REVERSED**.

SO ORDERED, this 9th day of March, 2016.

Steven W. Teate
Administrative Law Judge