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OFFICE OF ADMINISTRATIVE HEARINGS
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STATE OF NORTH CAROLINA

COUNTY OF NEW HANOVER

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
21 DHR 05363

Jeffrey Patrick Griffin Petitioner, v. Department of Health and Human Services, Division of Health Service Regulation Respondent.	**FINAL DECISION**

THIS MATTER came on for hearing before Hon. J. Randolph Ward, Administrative Law Judge, on May 13, 2022 in Bolivia. Following receipt of the parties proposed decisions, this Final Decision was prepared.

PROTECTIVE ORDER

Any personally identifying information related to residents of the subject facility appearing in the records of this proceeding shall be considered strictly confidential and must be used solely for the purpose of this proceeding alone and is not properly disclosed in any other setting or hearing, except by the order of the presiding judge.

APPEARANCES

Petitioner: Jesse Hamilton McCoy II, Clinical Prof. of Law, Supervising Atty.
Leila Ouchchy, Certified Legal Intern
Emily Chrisman, Certified Legal Intern
Duke Civil Justice Clinic
Durham, N.C.

Respondent: Farrah Raja, Associate Attorney General
N.C. Department of Justice
Raleigh, N.C.

EXHIBITS

Petitioner's Exhibit 6

Respondent's Exhibits A-P, and Q

WITNESSES

For Petitioner:	Jeffrey Griffin Beth Britt
For Respondent:	Denise Batchelder Sharon Adams Sherri Clark

STATUTES AND RULES AT ISSUE

N.C. Gen. Stat. §§ 131E-255(b); 131E-256(a)(1)a.; 10A NCAC 13O .0101(10), 42 CFR §483.12(a)(3) and 42 CFR § 488.301.

ISSUE

Whether the Petitioner, a Certified Nursing Assistant ("CNA"), "neglected" Resident "C.S.," within the meaning of 10A NCAC 13O .0101(10) and 42 CFR § 488.301, resulting in injury to her knee(s), at Trinity Grove, a residential nursing facility, on August 26, 2021.

UPON DUE CONSIDERATION of the arguments and stipulations of the parties; the exhibits admitted; and, the sworn testimony of each of the witnesses, viewed in light of their opportunity to see, hear, and know of relevant facts and occurrences, any interests they might have, and whether their testimony is reasonable and consistent with other credible evidence; and, upon assessing the preponderance of the evidence from the record as a whole in accordance with the applicable rules and laws, the undersigned makes the following:

FINDINGS OF FACT

1. On the date of the hearing, the Petitioner Jeffrey Patrick Griffin had been employed since October 28, 2020 with Trinity Grove, a long-term and memory care facility with a skilled nursing unit. He had been an assistant manager in dietary services there for the previous seven months. Prior to that, he had worked as a CNA at Trinity Grove and three similar facilities for 8 years. (R Ex B, p 25) Prior to that, he had "seven years experience in the restaurant business as a chef," but became a CNA because he wanted to tell his grandfather "before he passed away that I wanted to help people." Respondent's Exhibit B, Bates page 000025; Transcript of the Hearing, page 18, line 14 - page 19, line 17; page 110, line 16-17 (hereinafter, "R Ex B, p 25; Tr. 18:14-19:17; 110:16-17.")

2. On July 21, 2021, Resident "C.S.," and 82-year-old female, had been readmitted to Trinity Grove from an acute care hospital, Novant Health **New Hanover Regional Medical Center**. Her primary diagnosis was "Acute respiratory failure with hypoxia," with nine secondary diagnoses, including "Acute embolism and thrombosis of right femoral vein," and "Muscle

weakness (generalized)." She had spent other periods at Trinity Grove, going back to 2016. (R Ex M, p 119) C.S.'s Care Plan during her previous stay, from June 25 through August 26, 2021, included the diagnosis of "Acute embolism and thrombosis of the left tibial vein." (R Ex M, p 120-37) Trinity Grove's assistant director of nursing Elizabeth T. Britt, LPN described C.S. as suffering neuropathy with pain and numbness in her extremities on a daily basis, and required her legs to be elevated at night to reduce swelling and pain. She recounted that C.S.'s "favorite saying is her 'pain extends from her knees to her toes.'" Before her 2021 hospitalization, she was on the memory care unit "yelling and screaming and not knowing where she was," with a BIMS score bordering on severely impaired cognition.[1] Following the hospitalization, "she was better and able to return back to the long-term care side [of the Trinity Grove facility] but she still has periods of confusion and a new diagnosis of dementia." (P Ex 6, p 2)

3. On the morning of August 27, 2021, Denise Batchelder[2], a Licensed Practical Nurse, was dispensing medications to residents, including C.S. Ms. Batchelder asked C.S. about her pain to help her decide whether to give the patient Tylenol or a stronger medication, Norco, although she almost always gave the Norco. C.S. responded that one of her knees hurt and she wanted the stronger medication. Because her more common complaint was her feet, Ms. Batchelor asked what happen, and was told something like, "he hurt me" or "he was rough when he put me to bed last night." Since the Petitioner was only male on duty she asked if "he" was "Jeffrey," and C.S. said yes. She specifically asked her if her knee had been "hit," and she denied that, but associated the pain with the transfer process of moving her to her bed. Nurse Batchelder gave C.S. the Norco and examined her knees but did not see any swelling. She had not spoken to Petitioner about the allegation. (Tr 111:10-16; 115:6-116:14; 129:8-15; 112:21-24; 125:1-7; R Ex D, 37-38) When Nurse Britt interviewed C.S. later in the day, she could not remember if her alleged assailant was a "he" or a "she," and at first told her that the perpetrator was a "she." (P Ex 6, p 4)

4. Nurse Batchelder "was surprised because [she] had worked with Jeffrey and he was very patient and good with the patients," but had a duty to report allegations of mistreatment, and did so. (R Ex E, p 41-42) She told the Respondent's investigator that, "Jeffrey was a very good and compassionate with care and was really good with some difficult residents. … He was very passionate about the residents. I have worked with people for 30 years and I have no problem calling people out and saying they need to go but Jeffrey was compassionate about the care for the residents [and] from day one he came across as very caring and compassionate and it was upsetting for me to have to turn it in." (R Ex D, p 38-39)

5. Nurse Batchelder testified that C.S. was alert but "with periods of confusion," particularly in the "early morning and some sundowners in the evening." (R Ex D, p 37) The "CNA Guidelines for Daily Care" for C.S. said that "her short-term memory is poor and resident's decisions are made with difficulty." (R Ex N, p 144) Petitioner transferred C.S. from her wheelchair to her bed sometime within the timeframe of 7:30 PM–8:45 PM. (R Ex B, p 25) Her nursing notes for that evening at 10:35 PM and 12:40 AM record nothing out of the ordinary, and at 2:29 AM the nurse recorded "Positive Mood Noted." There was later swelling and application of ice, but this was consistent with a chronic condition similarly treated at least as far back as

[1] The "Brief Interview for Mental Status" scale is: 13-15 Intact Cognition, 8–12 Moderately Impaired Cognition, and 0–7 Severely Impaired Cognition.
[2] Ms. Batchelder testimony was taken telephonically pursuant to 26 NCAC 03 .0120(g).

February 2020. (R Ex C, p 33) Nurse Britt testified that she believed C.S.'s knee pain was related solely to neuropathy and osteoarthritis based on her history of knee pain complaints and the assessment of her condition made at the time of her complaints on August 27, 2021. (Tr 101:24-102:25)

6. The Petitioner credibly testified that on August 26, 2021, that C.S. to change her incontinence briefs, that he had done so, and that she had made no complaint and showed no signs of injury or upset. (Tr 22:20-23:14) He had previously told investigator that, "She never complained the entire time and no screaming and never said anything hurt." (R Ex B, p 26)

6. The facility properly investigated the matter as an allegation of "abuse."[3] Trinity Grove Administrator Logan Wilmouth notified C.S.'s son of the allegation and investigation on August 27, 2021. He responded that his mother would have contacted him or the sitter that was often with her in the daytime if the allegations were true, and that C.S. had not done so. (P Ex E, p 46)

7. Trinity Grove's investigators determined that the abuse accusation was unsubstantiated, and that C.S. "was not hurt" when Petitioner changed her incontinence brief and on August 26, 2021. (R Ex C, p 34) However, the inquiry revealed that Petitioner did not follow the C.S.'s individualized "CNA Guidelines for Daily Care" (or "Kardex[4]") when he transferred her from her wheelchair to her bed on August 26, 2021, without the observation or assistance of another person. While no actual harm was found in this instance, Petitioner was suspended for two weeks and required to retake the pertinent training and pass the associated tests before returning to work. (R Ex E, p 46; R Ex F, 58)

8. The Kardex / CNA Guidelines specify whether residents who are not ambulatory, such as C.S., should be aided in bathing, dressing, grooming, toileting, and other necessary activities, including transferring from wheelchair to bed. C.S. was "1 person" for all but "transfers" in August 2021, and that status had changed from time to time based on her strength. She was first was "1 person" following her discharge from the hospital on June 25, 2021, but was changed in July to "2 people standup lift," referencing a piece of assistive equipment (depicted in R Ex P, p 154) called a "Sit to Stand Lift." (Tr 164:21-165:1)

9. For the facilities investigation, Mr. Griffin wrote an account of his service to C.S. on August 26, 2021, including a detailed description of performing a "1 person" transfer -- *see* R Ex E, p 44-45 – and also credibly testified about the interaction at the hearing (at Tr 21:1-22:7). In summary, maneuver involved communicating with the resident about each of his movements, carefully lifting her from the wheelchair and placing her gently on the bed, and then maneuvering her into a comfortable position to allow him to change out her incontinence briefs. Notably, her knees were never in a position to bump into any of the surrounding furniture and equipment. (Tr 48:14-49:4)

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[3] "*Abuse* is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 CFR § 488.301

[4] Kardex is the name of the computer program the CNAs consult to see the "Guidelines" for each Patient.

10. The testimony showed that the second "person" has a modest but potentially important role in utilizing the "Sit to Stand Lift." At times, C.S.'s sitter served as the second person when Petitioner used the machine, although she was described as "not do[ing] any of the care." (R EX B, p 28; Tr 113:7-10) Petitioner testified that he would not use the Sit to Stand Lift without a second person, suggesting that two people would be needed if its battery failed. (Tr 52:14-53:12) Nurse Batchelder posed scenarios in which the resident could become imbalanced, and without steadying, could topple over. (Tr 114:17-115:2) It is apparent from the depiction (at R Ex P, p 154) that if staff needed support the patient, it would be very difficult to remove the straps from her legs at the same time without assistance.

11. Petitioner was remorseful about his violation of his workplace's rule, and but credibly testified that at the time he "was just focused on wanting to get my job done and do it right and help that patient out," and believed that he was taking care of Resident C.S. to the best of his ability. (Tr 40:22-23; 48:4-6) Sharon Adams, the facility's Director of Nursing, recounted to Respondent's investigator that Petitioner had readily admitted that he decided to take care of C.S. by himself, rather waiting for help and a Sit to Stand Lift machine, and commented that, "I think it [his decision] boiled down to him being strong and physically able to do it."

12. Objectively, he was correct. Mr. Griffin also testified that he thought might take 30 to 45 minutes to get the help of another member of the staff. Whether it took that long, or the "15 or 20 minutes" estimated by Nurse Britt, C.S. needed her incontinence briefs changed, and the sooner the better. She was anxious enough for relief to seek him out to do it. However, that was not management's sole consideration, and the facility was wholly justified in enforcing the work rule that would be safer given the abilities of most of their CNA's. Petitioner broke a work rule, and was justly disciplined. But he did not deny his patient services.

13. The preponderance of the credible evidence shows, by its greater weight that Petitioner did not cause or exacerbate C.S.'s knee pain on August 26, 2021.

27. Petitioner did not fail provide resident C.S. with the service necessary to avoid physical harm, pain, mental anguish, or emotional distress.

28. On or about December 1, 2021, the Respondent Department of Health and Human Services Division of Health Service Regulation notified Petitioner of its decision to list his name the Nurse Aide I Registry and the Health Care Personnel Registry for "neglect a resident (CS) by failing to use a person [to] assist with the Sit to Stand Lift when transferring the resident (CS), which was necessary to avoid pain and physical harm." Under the heading "Evidence Summary," the letter listed the components of its investigation. (R Ex G, p 69-71)

29. On December 15, 2021, Mr. Griffin timely filed a Petition in the Office of Administrative Hearings challenging the Respondent's decision to place his name in the Nurse's Aide Personnel Registry.

30. The Office of Administrative Hearings gave the parties due notice of hearing on April 6, 2022.

Based upon the foregoing Findings of Fact, the undersigned makes the following,

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction of the parties and the cause. N.C. Gen. Stat. §§ 131E-255(b); 150B-23.

2. In this contested case hearing, the Petitioner bears the burden of showing, by a preponderance of the evidence, that the Respondent erred in determining that he should have findings of neglect of a resident in a nursing facility entered against him in the Nurse Aide Registry maintained by the Respondent. N.C. Gen. Stat.§§ 131E-255(a); 150B-25.1(a); 150B-34(a).

3. A nursing facility must not "employ or otherwise engage individuals who . . . had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property[.]" 42 CFR §483.12(a)(3).

4. For the purposes of the Nurse Aide Registry, "*Neglect* is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." 10A NCAC 13O .0101; 42 CFR Part 488.301.

5. The preponderance of the credible evidence shows, by its greater weight, that the Petitioner did not fail to provide resident C.S. with the goods and services were necessary to avoid her physical harm, pain, mental anguish, or emotional distress.

6. OAH was created, in part, "[i]n an effort to obtain nonbiased hearing officers with specialized knowledge of the issues presented." *Employment Sec. Com'n of N.C. v. Peace*, 128 N.C. App. 1, 8, 493 S.E.2d 466, 471 (1997) *aff'd in part, review dismissed in part,* 349 N.C. 315, 507 S.E.2d 272 (1998). An administrative tribunal "is neither required nor permitted" to "shut its eyes to an established fact of common knowledge." *In re Prop. in Forsyth Co.,* 282 N.C. 71, 79, 191 S.E.2d 692, 697 (1972).

7. A judge is not required to find all the facts shown by the evidence, but only sufficient material facts to support the decision. *Green v. Green*, 284 S.E.2d 171,174, 54 N.C.App. 571, 575 (1981); *In re Custody of Stancil*, 179 S.E.2d 844,847, 10 N.C.App. 545, 549 (1971). Specific findings are not required on each piece of evidence presented. See *Flanders v. Gabriel*, 110 N.C.App. 438, 440, 429 S.E.2d 611, 612 (1993) (stating that the tribunal "need only find those facts which are material to the resolution of the dispute").

8. To the extent that the foregoing Findings of Fact contain conclusions of law, or that these Conclusions of Law are findings of fact, they are intended to be so considered without regard to their given labels. *Warren v. North Carolina Department of Crime Control and Public Safety*, 221 N.C. App. 376, 379, 726 S.E.2d 920, 923 (2012); *In re Simpson*, 211 N.C. App. 483, 487-88, 711 S.E.2d 165, 169 (2011) ("When this Court determines that findings of fact and conclusions of

law have been mislabeled by the trial court, we may reclassify them, where necessary, before applying our standard of review.").

Based upon the foregoing Findings of Fact and Conclusions of Law, the undersigned, makes the following

DECISION

The decision of the Respondent to enter findings that Petitioner neglected a nursing facility resident in the Nurse Aide I Registry and the Health Care Personnel Registry is **REVERSED**.

NOTICE OF APPEAL

This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34.

Under the provisions of North Carolina General Statute § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court of the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, the county where the contested case which resulted in the final decision was filed. **The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law Judge's Final Decision**. In conformity with the Office of Administrative Hearings' rule, 26 N.C. Admin. Code 03.0102, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, **this Final Decision was served on the parties as indicated by the Certificate of Service attached to this Final Decision**. N.C. Gen. Stat. § 150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under N.C. Gen. Stat. § 150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated in order to ensure the timely filing of the record.

IT IS SO ORDERED.

This the 29th day of July, 2022.

J Randolph Ward
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center who subsequently will place the foregoing document into an official depository of the United States Postal Service.

Jesse Hamilton McCoy II
Duke University School of Law Civil Justice Clinic
mccoy@law.duke.edu
Attorney for Petitioner

Charles R Holton
Duke Civil Justice Clinic
holton@law.duke.edu
Attorney For Petitioner

Farrah R. Raja
NCDOJ
fraja@ncdoj.gov
Attorney For Respondent

This the 29th day of July, 2022.

Daniel Chunko
Law Clerk
N. C. Office of Administrative Hearings
1711 New Hope Church Road
Raleigh, NC 27609-6285
Phone: 984-236-1850