STATE OF NORTH CAROLINA	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF NEW HANOVER	11 DHR 14184
MICHAEL TIMOTHY SMITH, JR., Petitioner, v. NC DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, Respondent.	**DECISION**

THIS MATTER came for hearing before the undersigned, Joe L. Webster, Administrative Law Judge, on May 14, 2012 in Courtroom #4 of the Bolivia County Government Complex in Bolivia, North Carolina.

APPEARANCES

For Petitioner: Michael Timothy Smith, Jr., Pro Se
4304 H Cedarwood Lane
Wilmington, NC 28401

For Respondent: Thomas E. Kelly
Associate Attorney
North Carolina Department of Justice
P.O. Box 629
Raleigh, North Carolina 27602

ISSUES

Whether Respondent otherwise substantially prejudiced Petitioner's rights and acted erroneously when Respondent substantiated the allegation that on or about September 20, 2011, Michael Smith, Jr. ("Petitioner"), a Resident Advisor with Strategic Behavioral Center, abused a resident ("C.L.") when he pushed the resident away from himself causing the resident to fall backward into a closet/cubicle resulting in the resident scraping and bruising his lower back.

Whether Respondent otherwise substantially prejudiced Petitioner's rights and acted erroneously when Respondent substantiated the allegation that on or about September 20, 2011, Petitioner neglected C.L. by failing to use proper intervention techniques to manage the resident's aggressive behavior resulting in physical harm to the resident.

APPLICABLE STATUTES AND RULES

N.C. Gen. Stat. § 131E-256
N.C. Gen. Stat. §150B-2
42 CFR § 488.301
10A N.C.A.C. 13O.0101

EXHIBITS

Respondent's exhibits 1 – 27 were admitted into the record.

WITNESSES

For Respondent: Justin Crowl
Susan Stewart
Margaret Martin

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing and the entire record in this proceeding, the Undersigned makes the following findings of fact. In making the findings of fact, the Undersigned has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate factors for judging credibility, including, but not limited to, the demeanor of the witness, any interests, bias, or prejudice the witness may have, the opportunity of the witness to see, hear, know or remember the facts or occurrences about which the witness testified, whether the testimony of the witness is reasonable, and whether the testimony is consistent with all other believable evidence in the case. From the sworn testimony of witnesses, the undersigned makes the following:

FINDINGS OF FACT

1. At all times relevant to this action, Petitioner was employed as a Resident Advisor with Strategic Behavior Center ("Strategic") in Leland, North Carolina and therefore subject to N.C. Gen. Stat. § 131E-256. (Resp. Ex. 4)

2. Petitioner completed all required training related to his job responsibilities. He also received instruction on abuse, neglect, and exploitation. (Resp. Ex. 2-7)

3. Strategic trained Petitioner on intervention techniques. This training instructed employees on how to handle residents showing signs of verbal and/or physical aggression towards other residents and staff. Specifically, Strategic trained employees to "never physically hurt or be a psychological risk to the client at any time." (Resp. Ex. 2-7)

4. At the time of the incident, C.L. was approximately seventeen years old and suffered from attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder, mood disorder, marijuana abuse, and Von Willebrand disease. (Resp. Ex. 22)

5. Petitioner reported to work at Strategic on September 20, 2011, the relevant time period for this action. (Resp. Ex. 9)

6. C.L. took milk and cereal from the dayroom into his room. Petitioner followed C.L. into his room and prompted him to return to the dayroom with his breakfast. C.L. responded by becoming physically aggressive, making verbal threats, yelling, and arguing with Petitioner. Petitioner was standing very close to C.L. (Resp. Ex. 13-14)

7. C.L. threw the milk and cereal toward Petitioner's head, though neither physically struck Petitioner. (Resp. Ex. 13)

8. In response, Petitioner pushed C.L. with both hands and C.L. fell back three to four feet into his closet/cubicle. (Resp. Ex. 13)

9. C.L stood up after being pushed, and charged at Petitioner, striking him on his shoulder. (Resp. Ex. 13-14)

10. After hearing the altercation, Justin Crowl ("Crowl") entered the room and placed C.L. into a Physical Restraint Technique (PRT) hold. After C.L. calmed down, he was released from the hold. Crowl is a fellow Resident Advisor at Strategic. (Resp. Ex. 13-14)

11. Crowl proceeded to call Code Purple. A Code Purple signals to Strategic staff that a patient is physically or verbally escalating a situation beyond the control of a staff member. Under a Code Purple, the patient can be redirected by another staff member or placed into a therapeutic hold. Once a Code Purple is called, a team of staff members, including a registered nurse, are trained to report to assist with the situation. (Resp. Ex. 20)

12. Phillip Brice ("Brice"), a Hall Leader at Strategic, also entered the room. Petitioner was upset after the altercation and Brice removed him from the room. Brice returned to C.L. and inspected him for injuries after the altercation. Brice noted a red abrasion mark on C.L.'s lower back. (Resp. Ex. 13-14, 20)

13. Dianne Ferguson, ("Ferguson") responded to the Code Purple by entering the room and found C.L. in a PRT hold. Ferguson is the Code Purple Team Nurse at Strategic. C.L. showed Ferguson an abrasion on his lower back and left lateral elbow. Ferguson cleaned and applied triple antibiotic ointment on the injuries. Afterward, Ferguson documented the wounds. (Resp. Ex. 20)

14. Susan Stewart ("Stewart"), director of Risk Management at Strategic, was notified of the incident by the administrator on call, Allison D'Amico. (Resp. Ex. 21)

15. Stewart led the Strategic investigation into the incident and she interviewed C.L., Ferguson, Brice, Crowl, and Petitioner. (Resp. Ex. 16)

16. Stewart sent a 5-Working Day Report to the Health Care Personnel Registry

("HCPR"), documenting the Strategic investigation and its findings. (Resp. Ex. 17)

17. On September 23, 2011, Stewart produced an investigation conclusion report, detailing the interviews and written staff statements obtained. Based upon the findings of the investigation, the allegation of abuse against Petitioner was substantiated. (Resp. Ex. 16)

18. As a result of the investigation, Petitioner's employment was terminated by Strategic on September 23, 2011. (Resp. Ex. 16)

19. Stewart produced an Incident Response Improvement System ("IRIS") Report and sent it to the local management entity ("LME") for Strategic. The guardian for C.L., the Department of Social Services ("DSS"), and the Brunswick County Sheriff Department were also notified of the incident. (Resp. Ex. 21)

20. The HCPR investigates allegations of abuse, neglect, exploitation, and misappropriation of resident property involving health care personnel that are employed by health care facilities. If an allegation is substantiated, the employee will be listed in the HCPR. The HCPR covers most licensed facilities that provide patient care in North Carolina. Accordingly, health care personnel at Strategic are covered by the HCPR. (Resp. Ex. 27)

21. At all times relevant to this action, Margaret Martin ("Martin") was employed as a Nurse Investigator for the HCPR. She was charged with investigating allegations against health care personnel in the city of Leland, NC. Accordingly, Martin received and investigated the allegation that Petitioner had abused Resident C.L. at Strategic. (Resp. Ex. 27)

22. Upon receipt of the 5-Working Day Report, Martin "screened in" the case for further investigation on November 4, 2011. (Resp. Ex. 26)

23. Martin reviewed Petitioner's personnel file from Strategic and determined that Petitioner received all the training necessary to properly perform his job duties. (Resp. Ex. 26)

24. Martin reviewed C.L.'s medical records. She confirmed that C.L. suffered from attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder, mood disorder, marijuana abuse, and Von Willebrand disease. (Resp. Ex. 26)

25. Martin interviewed Crowl on December 20, 2011. Crowl witnessed C.L. taking his milk and cereal from the dayroom into his room. Crowl watched as Petitioner followed C.L. into his room and prompted him to return to the dayroom with his breakfast. C.L. became physically aggressive making verbal threats, yelling, and arguing with Petitioner. Petitioner and C.L. were standing face to face. C.L. then threw the milk and cereal toward Petitioner's head. Petitioner reacted by pushing C.L. with his hands and C.L. fell back three to four feet into his closet/cubicle. C.L got up, charged, and hit Petitioner on his shoulder. Crowl entered the room and immediately placed C.L. into a PRT. Martin found Crowl's statement to be consistent with the information collected by the Strategic investigation. (Resp. Ex. 26)

26. Martin interviewed Ferguson on December 20, 2011. Ferguson recalled coming into CL's room after the Code Purple was called. Ferguson cleaned and applied medication on abrasions that she identified on C.L.'s lower back and left lateral elbow. (Resp. Ex. 26)

27. Martin interviewed Brice on December 20, 2011. Brice told Martin that he was sitting in the day room and heard a commotion. Brice went to C.L.'s room where he heard C.L. say, "M—F---, you pushed me" to Petitioner. C.L. was going after Petitioner when Crowl placed C.L. in a restraint. Brice did not see Petitioner punch C.L. However, Brice did see a mark on C.L.'s back resembling a carpet burn immediately after C.L. was released from the PRT. Martin found Brice's statement to be consistent with the information collected by the Strategic investigation. (Resp. Ex. 26)

28. Martin interviewed Stewart on December 20, 2011. Stewart told Martin that she conducted the facility investigation. Stewart stated that Petitioner received training regarding dealing with verbally and physically aggressive residents. Petitioner was also trained on de-escalation techniques, therapeutic holds, and calling Code Purple. The facility supplements training with written policies regarding verbally and physically aggressive residents. Stewart was notified of the incident on September 21, 2011, the day the incident occurred. Stewart interviewed C.L., who stated that he and Petitioner were yelling at one another in his room. C.L. put his hands on Petitioner and ripped Petitioner's shirt. Petitioner responded by pushing C.L., causing C.L. to fall and scrape his lower back. Stewart substantiated the allegations against Petitioner and terminated Petitioner. (Resp. Ex. 26)

29. Martin interviewed Petitioner on January 31, 2012. Petitioner stated that he followed C.L. into the room after seeing CL. bring his breakfast into his room. Petitioner told C.L. that he was not allowed to have food in his room. Petitioner prompted C.L. two times to remove the food from the room. At the third prompt, C.L. became aggressive. In response, Petitioner began performing a PRT on C.L. During the PRT, C.L. was pressed against cubbies, causing Petitioner's shirt to rip. Crowl entered the room and restrained C.L. Petitioner claimed that he did not push C.L. into the cubby. (Resp. Ex. 26)

30. Martin assessed all the information collected through her investigation, including the written statements collected by Strategic investigator, the HCPR interviews, and the documentation provided by Strategic. Martin concluded that on September 21, 2011, Petitioner abused and neglected C.L. by pushing the resident and by failing to use proper intervention techniques to manage the resident's uncooperative and aggressive behavior resulting in physical harm. (Resp. Ex. 26)

31. Petitioner was notified by letter that a finding of abuse and neglect would be listed against his name in the Health Care Personnel Registry. Petitioner was further notified of his right to appeal. (Resp. Ex. 27)

32. Petitioner is not disabled and has the ability to work. The listing on the Health Care Personnel Registry limits his ability to work in the health care field. Petitioner is still able to work in other fields.

33. This matter came for hearing before the undersigned, Joe L. Webster, Administrative Law Judge, on May 14, 2012 in Boliva, North Carolina.

Based upon the foregoing Findings of Fact, the undersigned Administrative Law Judge makes the following:

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter pursuant to N.C. Gen. Stat. §§ 131E and 150B *et seq.*

2. All parties have been correctly designated and there is no question as to misjoinder or nonjoinder.

3. The North Carolina Department of Health and Human Services, Division of Health Service Regulation, Health Care Personnel Registry Section is required by N.C. Gen. Stat. § 131E-256 to maintain a Registry that contains the names of all health care personnel and nurse aides working in health care facilities who are subject to a finding by the Department that they abused a resident in a health care facility or who have been accused of abusing a resident if the Department has screened the allegation and determined that an investigation is warranted.

4. As a Resident Advisor, Petitioner is subject to the provisions of N.C. Gen. Stat. § 131E-256.

5. Strategic of Leland, North Carolina is a health care facility as defined in N.C. Gen. Stat. § 131E-255(c) and N.C. Gen. Stat. § 131E-256(b).

6. "Abuse" is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." 10A N.C.A.C. 13O.0101, 42 CFR § 488.301.

7. On September 21, 2011, Petitioner abused a resident ("C.L.") when Petitioner pushed the resident causing him to fall backwards into a cubby/closet resulting in scraping and bruising on the resident's lower back.

8. "Neglect" is defined as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 10A N.C.A.C. 13O.0101, 42 CFR § 488.301.

9. On September 21, 2011, Petitioner neglected a resident ("C.L.") when he failed to use proper intervention techniques to manage the resident's behavior resulting in physical harm to the patient.

10. Respondent's decision to substantiate the allegations of abuse and neglect against Petitioner is supported by a preponderance of the evidence. Therefore, Respondent did not

substantially prejudice Petitioner's rights, act erroneously, arbitrarily or capriciously by placing a substantiated finding of abuse against Petitioner's name on the Health Care Personnel Registry and the Nurse Aid Registry.

Based on the foregoing Findings of Fact and Conclusions of Law, the Undersigned makes the following:

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the undersigned hereby determines that Respondent's decision to place a finding of abuse and neglect at Petitioner's name on the Health Care Personnel Registry should be **UPHELD**.

NOTICE

The Agency that will make the final decision in this contested case is the North Carolina Department of Health and Human Resources, Division of Facility Services.

The Agency is required to give each party an opportunity to file exceptions to the recommended decision and to present written arguments to those in the Agency who will make the final decision. N.C. Gen. Stat. § 150-36(a). The Agency is required by N.C. Gen. Stat. § 150B-36(b) to serve a copy of the final decision on all parties and to furnish a copy to the parties' attorney of record and to the Office of Administrative Hearings.

In accordance with N.C. Gen. Stat. § 150B-36 the Agency shall adopt each finding of fact contained in the Administrative Law Judge's decision unless the finding is clearly contrary to the preponderance of the admissible evidence. For each finding of fact not adopted by the agency, the agency shall set forth separately and in detail the reasons for not adopting the finding of fact and the evidence in the record relied upon by the agency in not adopting the finding of fact. For each new finding of fact made by the agency that is not contained in the Administrative Law Judge's decision, the agency shall set forth separately and in detail the evidence in the record relied upon by the agency in making the finding of fact.

This the 1st day of August, 2012.

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Joe L. Webster
Administrative Law Judge

A copy of the foregoing was mailed to:

Michael Smith
Petitioner
4304 H. Cedarwood Lane
Wilmington, NC 28401

Thomas E. Kelly
Associate Attorney
North Carolina Department of Justice
Human Services
P.O. Box 629
Raleigh, NC 27602
COUNSEL FOR RESPONDENT

This the _____ day of August, 2012.

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Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6714
(919) 733-2698
Fax: (919) 733-3407