

IN THE OFFICE OF  
ADMINISTRATIVE HEARINGS

13 DHR 10037

V.

## ADMINISTRATIVE LAW JUDGE'S FINAL DECISION

N.C. Gen. Stat. § 131E-256

**EXHIBITS**

Respondent's exhibits 1-21, 23-27 were admitted into the record.

**WITNESSES**

Teresa Anne Davis (petitioner)  
Faye Coleman Moore (CNA)  
Nehemie J. Janvier (LPN)  
Jennifer Catherine Whiting (Director of Nursing)  
John Wall (Administrator)  
Kathy Moshman (HCPR Nurse Investigator)

**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. Petitioner, Teresa Anne Davis, was employed for eleven years as a Certified Nursing Assistant (CNA) at Five Oaks Manor ("Five Oaks") in Concord, North Carolina. Five Oaks is a nursing home facility. It is therefore subject to N.C. Gen. Stats. §131E-255 and §131E-256. (T. pp. 10-11; Resp't Exs. 2, 7)
2. Petitioner was trained for her position and received an orientation at Five Oaks. Petitioner's training included nursing care, abuse, neglect, safety, and observing disoriented residents. Petitioner was also trained to report all changes in the resident's condition to the charge nurse as soon as practical. Based on Five Oaks training, employees are required to back away from agitated residents and notify the nurse immediately. (T. pp. 11-12, 29-30; Resp't Exs. 1-3)
3. Petitioner's job responsibilities included ensuring safety of residents and appropriate nursing care, observation, and treatment. Petitioner also read and signed the

Five Oaks employee handbook, attesting to her affirmation regarding the Employee Code of Standards and Code of Conduct. (T. pp. 28-29; Resp't Ex. 1)

4. Petitioner was working a double shift at Five Oaks on December 18, 2012. Petitioner was assigned to take care of Resident EM as a "one-on-one" patient. As Resident EM's one-on-one staff, Petitioner was required to take care of only Resident EM during the shift. (T. p. 37; Resp't Exs. 4-5)

5. Petitioner had taken care of Resident EM approximately five days a week over a three-month period and was familiar with Resident EM's care. Resident EM's medical diagnoses included: dementia, diabetes, cognitive impairment, and a history of psychosis. (T. pp. 13-14, 44, 68, 77-78, 109, 116; Resp't Exs. 17-19)

6. Resident EM awakened around midnight and became agitated. Resident EM began swinging her arms and attempted getting out of bed. Resident EM also attempted throwing a bedside table and chair at Petitioner. Petitioner then called a nurse to give Resident EM something to calm her down. (T. pp. 13-14; Resp't Exs. 5, 7)

7. A few hours after the drug was administered, Resident EM became agitated again and began swinging her arms and grabbing her head. Petitioner did not seek a nurse for assistance, as Petitioner erroneously believed that EM could not receive any more medication or that a nurse's intervention was otherwise unnecessary. As Resident EM swung her hands, she hit her hand against the footboard of her bed. After Resident EM hit her hand, Petitioner informed a coworker, Faye Coleman Moore ("Ms. Moore"). (T. pp. 14-16, 23, 50-51; Resp't Exs. 5, 7)

8. Ms. Moore notified Nurse Janvier of the injury, and Nurse Janvier immediately came to check on Resident EM's hand. Nurse Janvier was employed at Five Oaks as a Licensed Practical Nurse (LPN). Before the incident occurred, Nurse Janvier had administered medication to Resident EM to calm her down. After the incident occurred, Nurse Janvier evaluated Resident EM's hand and called for an X-ray. It was later determined that Resident EM fractured her hand. (T. pp. 15, 23, 57-59, 61-62, 65, 69; Resp't Exs. 11-13, 20-21)

9. Jennifer Catherine Whiting ("Ms. Whiting") and John Wall ("Mr. Wall") were employed at Five Oaks as the Director of Nursing and Administrator respectively. Ms. Whiting and Mr. Wall completed the facility investigation of the incident. (T. pp. 73-75, 79-80, 85, 96-100; Resp't Exs. 5-6, 12, 14)

10. At the conclusion of the facility investigation, Five Oaks terminated Petitioner's employment and reported the incident to the Health Care Personnel Registry. (T. p. 107; Resp't Exs. 16, 24, 26)

11. Kathy Moshman ("Nurse Investigator Moshman") was an investigator with the Health Care Personnel Registry. Nurse Investigator Moshman is charged with investigating allegations against health care personnel in the south central region of North

Carolina, including Cabarrus County. Accordingly, she received the report that Petitioner had abused and neglected Resident EM at Five Oaks. (T. pp. 105, 107; Resp't Exs. 16, 26)

12. Nurse Investigator Moshman independently conducted her own investigation and reviewed the facility documents. As part of her investigation, Nurse Investigator Moshman interviewed Mr. Wall, Ms. Whiting, Petitioner, Ms. Janvier, and Ms. Moore. At the conclusion of her investigation Nurse Investigator Moshman unsubstantiated the allegation of abuse and substantiated the allegation of neglect. (T. pp. 107-108, 115-117; Resp't Exs. 7, 10, 13, 15-16, 23-27)

13. Following the conclusions of her investigation, Nurse Investigator Moshman notified Petitioner of her decision to substantiate the allegation of neglect. (T. pp. 115-117; Resp't Exs. 24, 26-27)

14. "Neglect" is defined as "the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental abuse." (T. p. 115)

15. A finding of Neglect may be petitioned to be removed after a year of being placed on the registry. (T. p. 117)

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 chapters 131E and 150B of the North Carolina General Statutes.

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

3. As a Certified Nursing Assistant working in a nursing home facility, Petitioner is a health care personnel and is subject to the provisions of N.C. Gen. Stat. § 131E-255 and § 131E-256.

4. "Neglect" is defined as "the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental abuse." 10A NCAC 130.0101.

5. Petitioner has the burden of proving Respondent otherwise substantially prejudiced Petitioner's rights and failed to act as required by law or rule when Respondent substantiated the allegation that Petitioner neglected a resident of Five Oaks

Manor in Concord, NC and entered findings of neglect by Petitioner's name in the Health Care Personnel Registry. Overcash v. N.C. Dep't of Env't & Natural Res., 179 N.C. App. 697, 704 (N.C. Ct. App. 2006).

6. Petitioner did not carry her burden. Petitioner failed to adequately explain why she did not report Resident EM's agitation to the nurse on duty. As Resident EM's one-on-one staff, Petitioner had a heightened duty to report changes in Resident EM's agitation for Resident EM's protection. Petitioner's responsibility was only to this patient. By summoning the nurse, Petitioner likely could have avoided the injury to the only individual in her care and avoided this patient's substantiated injury. Petitioner's explanation as to why she failed to summon assistance did not satisfy her burden of proof as to Respondent's finding.

7. On or about December 18, 2012, Petitioner neglected Resident EM by failing to intervene to prevent the resident from being injured during an agitated state. Petitioner's primary duty during the shift was to monitor Resident EM. Resident EM's agitation was not a sudden occurrence but a chronic problem during Petitioner's shift on December 18, 2012. As an eleven-year employee of Five Oaks, Petitioner was familiar with reporting procedures and the availability of sedative medications that could have been ordered from the nurse's station as had been done earlier that evening. Petitioner was unresponsive and inattentive to her responsibilities for the only patient under her care. Petitioner's failure to seek assistance increased the probability of Resident EM's injury.

8. Respondent did not act erroneously because there is sufficient evidence to support Respondent's conclusion that Petitioner neglected Resident EM. Petitioner was neither charged with abuse nor does the evidence justify such a finding. Petitioner's decision not to seek immediate assistance was a poor exercise of professional judgment and falls within the definition of neglect. Petitioner neglected to take appropriate action. By her failure, Petitioner exercised poor judgment in this instance and an injury occurred to a resident within her care. Petitioner is, otherwise, a good caregiver. Based upon Petitioner's record, this is an isolated incidence. Petitioner should at the appropriate time be allowed to reapply for certification.

### **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 neglect by Petitioner's name on the Nurse Aide Registry and the Health Care Personnel Registry should be **AFFIRMED**.

### **NOTICE**

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 Wake County or in the Superior Court of the county in which the party resides. 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 03.012 and the Rules of Civil Procedure, N.C. General Statute §1A-1, Article 2, this Final Decision was served on the parties the date it was placed in the mail as indicated by the date on 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.

This the 20th day of September, 2013.

---

Julian Mann  
Chief Administrative Law Judge