STATE OF NORTH CAROLINA

COUNTY OF GUILFORD

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
13 DHR 11850

PRISCILLA DARKWA,
Petitioner,

v.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION,
Respondent.

FINAL DECISION

This contested case came on for hearing before the Undersigned, Julian Mann III, Chief Administrative Law Judge, on August 26, 2013 in High Point, North Carolina. Respondent's Proposed Final Decision was filed on October 2, 2013. Petitioner's counsel did not file a proposed decision. The record closed on October 13, 2013.

APPEARANCES

For Petitioner: Daniel C. Nash
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For Respondent: Thomas E. Kelly
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ISSUE

Whether 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 Blumenthal Jewish Nursing & Rehabilitation Center in Greensboro, NC and entered a finding of neglect by Petitioner's name in the Health Care Personnel Registry.

APPLICABLE STATUTES AND RULES

N.C. Gen. Stat. § 131E-255
N.C. Gen. Stat. § 131E-256
N.C. Gen. Stat. §150B-23
42 CFR § 488.301

10A N.C.A.C. 130 .0101

EXHIBITS

Respondent's exhibits 1 – 8, 10 – 15, and 18 – 23 were admitted into the record.

WITNESSES

Priscilla Darkwa (Petitioner)
Beverly Jane Weary (Registered Nurse, DON)
Jeanne M. Goss (HCPR 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. For approximately seven months, Priscilla Darkwa ("Petitioner") was a Nursing Assistant at Blumenthal Jewish Nursing and Rehabilitation Center ("BJNRC") in Greensboro, North Carolina, and therefore subject to N.C. Gen. Stat. § 131E-256. (Tr. p. 13)

2. BJNRC is a health care facility as defined by NC. Gen. Stat. § 131E-256; therefore, its employees are subject to the jurisdiction of the Health Care Personnel Registry.

3. As a Nursing Assistant, Petitioner's duties primarily involved making routine rounds on each assigned resident every two hours, dressing residents, toileting residents, and providing skin care. (Tr. pp. 14-17; Resp. Ex. 1)

4. Petitioner completed the Residents' Rights and Abuse/Neglect Reporting training during her orientation at BJNRC on May 9, 2012. This training includes the Abuse and Neglect Prohibition Program Policy Manual, which defines neglect as the "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." (Resp. Exs. 3, 22)

5. M.F. was a resident of BJNRC, was eighty-seven (87) years old, and her diagnoses included: hypothyroidism; anemia; atrial fibrillation; difficulty walking; muscle weakness; and lack of coordination. (Resp. Ex. 21)

6. On December 12, 2012, Petitioner was scheduled to work the second shift and was specifically assigned to portions of the 300 and 400 halls. (Tr. pp. 44-45; Resp. Ex. 5)

7. M.F.'s room was located on the 400 hall, and therefore, Petitioner was assigned to M.F.'s room on that day. (Tr. pp. 44-46)

8. Petitioner was responsible for toileting M.F., who was deemed incontinent. Accordingly, Petitioner was required to put a diaper on M.F. or to assist M.F. with the use of a bedpan, if so desired. On the day prior to the alleged incident, December 11, 2012, Petitioner placed M.F. on a fracture bedpan. M.F. required the use of a fracture bedpan. Fracture bedpans are designed for residents suffering from hip fractures and are smaller in size to relieve pressure on the hip. (Tr. pp. 15-16, 46-47)

9. Shirlene Cuthbertson, a CNA at BJNRC, was the person responsible for M.F. during the first shift. Therefore, Ms. Cuthbertson's assignment was immediately preceding Petitioner's shift on December 12, 2012. Petitioner spoke with Ms. Cuthbertson before Petitioner's shift began and neither asked for a hand-off report nor discussed M.F. with Ms. Cuthbertson at that time. (Tr. pp. 27-29)

10. During Petitioner's shift, Ms. Cuthbertson asked Petitioner to help put M.F. on a bedpan. Petitioner agreed to do so. However, Petitioner was assisting another patient when Ms. Cuthbertson was ready to proceed. As such, Ms. Cuthbertson called another second shift CNA, Valisia Morgan, to help her place M.F. on the bedpan. (Tr. pp. 28-30)

11. Petitioner saw both Ms. Cuthbertson and Ms. Morgan later in the shift after they placed M.F. on the bedpan. Petitioner neither spoke with Ms. Cuthbertson concerning M.F. nor did she speak with Ms. Morgan. However, Petitioner but did converse with both regarding other matters. (Tr. pp. 30-32)

12. Petitioner did not offer any toileting care to M.F. on December 12, 2012. Petitioner took M.F.'s vital signs, which were normal, and left M.F.'s room. Petitioner was unaware that M.F. remained on the bedpan. (Resp. Ex 19) (Tr. pp. 33-35)

13. It is BJNRC policy to check on all residents at least once every two hours. Petitioner checked on M.F. twice during her second shift: once to pull the curtains at M.F.'s request and once to see if M.F. needed anything, generally. During her second visit, Petitioner checked M.F. to see if her bed pad was wet. Petitioner found the pad was still white in color and determined that M.F. did not need additional care. (Tr. pp. 35-38)

14. At no point in time did Petitioner check to see if M.F. was still on the fracture pan. (Tr. p. 39)

15. Petitioner was required to do perform many duties set forth in BJNRC's PM Care Policy Manual. First, Petitioner was required to physically turn M.F. over while providing care. Petitioner did not do so. Furthermore, Petitioner was required to offer a bedpan to M.F., which she did not do. Lastly, Petitioner was required to "assist resident into a comfortable position. Turn and position the resident with pillows." Petitioner did not perform this duty. Petitioner did,

however, offer to do such things for M.F., but M.F. refused such care. (Tr. pp. 48-50, 55-56)

16. Petitioner was trained that she should not provide care against a resident's wish or will, but was instructed to always report any such events to the nurse. Petitioner only reported M.F.'s vital signs to the nurse. Petitioner did not make any mention of the required tasks that were not performed at M.F.'s request. (Tr. pp. 50-52)

17. Petitioner never checked to see if M.F. was on a bedpan, other than checking the pad. Petitioner's shift was eight hours long, and during that time, M.F. had not used the bathroom or asked to use the bathroom at all. Petitioner said this did not give her any cause for alarm. (Tr. pp. 54-55)

18. On December 13, 2012, Beverly Weary, RN/DON at BJNRC, notified Petitioner of injuries sustained by M.F. from being left on a bedpan throughout Petitioner's shift and throughout the night. Petitioner provided a statement detailing her actions on December 12, 2012 involving M.F. BJNRC conducted an investigation and terminated Petitioner's employment based on its investigation. (Tr. pp. 57-62)

19. Petitioner spoke with Jeanne Goss ("Goss"), the HCPR investigator, who investigated Petitioner's actions. Goss worked as an investigator for the Health Care Personnel Registry. NJNRC was part of her assigned territory. Petitioner willingly admitted that she "can't just assume that a resident is alert and oriented just because they were once" and that she was responsible for the incident involving M.F. Further, Petitioner claimed that she "should have gone further" in her care of M.F., and was "at fault, too, and was sorry that it happened." Petitioner's actions were not intentional but occurred by her failure to discover that the bedpan was still in place. (Tr. pp. 63-64, 104-105; Resp. Ex. 19)

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.

21. Goss became involved in the case after receiving the twenty-four hour and five-working day reports from BJNRC. She further reviewed other BJNRC documents and independently conducted an investigation. As part of her investigation Goss made two on-site visits and conducted interviews with witnesses. (Tr. pp. 106-110; Resp. Exs. 12-15, 18-20)

22. Based upon the findings of the HCPR investigation, Goss substantiated the allegation of neglect against Petitioner and notified Petitioner of her decision. (Tr. p. 121; Resp. Ex. 22-23)

23. Petitioner had been certified for less than a year.

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 Nursing Assistant in a nursing and rehabilitation center, 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 a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 10A N.C.A.C. 130.0101, 42 C.F.R. § 488.301. Petitioner neglected Resident M.F. by failing to provide services to M.F. to avoid harm. Petitioner's action was not intentional.

5. On December 12, 2012, Priscilla Darkwa, a Nurse Aid, neglected Resident M.F. by failing to remove the resident from the bedpan for the duration of her shift resulting in redness and blisters to the resident's buttocks.

6. Respondent's decision to substantiate this allegation of 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 neglect against Petitioner's name on the Health Care Personnel Registry.

7. Petitioner was inexperienced, failed to discover the bedpan, and was apologetic for her failure. Petitioner accepted responsibility.

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

DECISION

Respondent's decision to place a finding of neglect by Petitioner's name on the Health Care Personnel Registry should be **UPHELD**.

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 2nd day of December, 2013.

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Julian Mann III
Chief Administrative Law Judge