

STATE OF NORTH CAROLINA  
COUNTY OF GUILFORD

IN THE OFFICE OF  
ADMINISTRATIVE HEARINGS  
13DHR12691

<p>Pamela Byrd, Petitioner,</p> <p>v.</p> <p>North Carolina Department Of Health And Human Services, Respondent.</p>	<p><b>FINAL DECISION</b></p>
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THIS MATTER came on for hearing before Beecher R. Gray, Administrative Law Judge presiding, on September 23, 2013, in the Martin Courtroom at the Guilford County Courthouse in High Point, North Carolina. The undersigned Administrative Law Judge issues the following Decision, which is a final decision under the North Carolina Administrative Procedure Act, N.C. Gen. Stat. § 150B-34:

#### **APPEARANCES**

For Petitioner:      Maureen Demarest Murray  
                              Smith Moore Leatherwood LLP  
                              300 N. Greene Street, Suite 1400  
                              Greensboro, NC 27401

For Respondent:     Josephine N. Tetteh  
                              Assistant Attorney General  
                              N.C. Department of Justice  
                              P. O. Box 629  
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#### **ISSUE**

Whether Respondent substantially prejudiced Petitioner's rights by failing to act as required by law or rule, exceeding its authority and jurisdiction, acting arbitrarily and capriciously, and failing to use proper procedure when Respondent substantiated the allegation that Petitioner neglected a resident ("C.W.") of RHA Howell/Westminster Group Home, 1111 Westridge Road in Greensboro, North Carolina, by failing to follow the correct method of transferring C.W., which resulted in a cut to C.W.'s head that required staples.

**APPLICABLE STATUTES AND RULES**

N.C. Gen. Stat. § 131E-256  
N.C. Gen. Stat. § 150B-1, *et seq.*  
42 CFR § 488.301  
10A N.C.A.C. 130.0101

**EXHIBITS**

Respondent's Exhibits ("R. Exs.") 1–18 were admitted into the record without objection.

**WITNESSES**

**For Petitioner**

None

**For Respondent**

Pamela Tonya Byrd (Petitioner)  
Rhonda English, LPN, RHA Howell/Westminster  
Deborah Foster, Clinical Coordinator, RHA Howell/Westminster  
Kandy John, Administrator, RHA Howell/Westminster  
Jennifer Baxter, RN, BSN (Investigator, Health Care Personnel Registry)

**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 and conclusions of law. 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 witnesses; any interests, bias, or prejudice the witnesses may have; the opportunity of the witnesses to see, hear, know, or remember the facts or occurrences about which the witnesses testified; whether the testimony of the witnesses is reasonable; and whether the testimony is consistent with all other believable evidence in the case. From the sworn testimony of the witnesses, the Undersigned makes the following:

**FINDINGS OF FACT**

1. The parties received notice of hearing by certified mail more than 15 days prior to the hearing, and each stipulated on the record that notice was proper.
2. Both parties requested and agreed to recording of the hearing by Mr. William Dobbins, Hearing Assistant.

3. At all times relevant to this matter, Pamela Tonya Byrd (“Petitioner”) was employed as a health care personnel, a Developmental Technician at RHA Howell/Westminster, 1111 Westridge Road in Greensboro, North Carolina.
4. RHA Howell/Westminster is a Group Home for developmentally disabled adults operated by RHA and located at 1111 Westridge Road in Greensboro. Six female residents lived in the facility as of February 15, 2013, the time of the events giving rise to this contested case.
5. Petitioner’s duties as a Developmental Technician included providing direct care to disabled residents, assisting with personal hygiene, preparing meals, assisting with programming and activities, dealing with residents’ behaviors, and interacting with residents. (R. Ex. 1)
6. Petitioner received, and acknowledged having received, training in proper transfers of residents including two-person lifts and use of a Hoyer lift. (R. Ex. 2)
7. Petitioner generally worked the evening shift where she was responsible for preparing and serving meals to residents, assisting with bathing and daily hygiene, evening interaction, provision of medications to residents, and assistance with preparation for bed.
8. On February 15, 2013, Petitioner and Sabrina Jernigan, another Developmental Technician, were working in the facility. Six female residents were present in the facility at the time. No other staff were present in the facility.
9. On February 15, 2013, Petitioner was assigned to provide direct care to C.W. C.W. is a 69-year-old female, 114 pounds, with diagnoses of osteoporosis, kyphosis, cerebral palsy, seizure disorder, and mental retardation. (R. Ex. 6 )
10. According to a physical therapy evaluation done on January 4, 2012, C.W. was non-ambulatory, able to self-propel her manual wheelchair, lift herself up to relieve pressure in her wheelchair, feed herself, raise herself from a supine to a sitting position in bed, and scoot herself up in her bed. C.W. also understood and responded to verbal commands. The physical therapy evaluation also stated that C.W. was independent with bed mobility. (R. Ex. 6)
11. Written statements by Petitioner and Sabrina Jernigan describe C.W. as playful. (R. Exs. 3 & 4) Clinical Coordinator Deborah Foster confirmed that C.W. liked to interact and to give staff big hugs.
12. In her written statements, Petitioner described C.W. as able to change her position in bed to lie crossways or horizontally on the bed rather than vertically. (R. Exs. 3 & 4) Petitioner included with her written statement a diagram of C.W.’s position lying horizontally on the bed. During her investigation, Health Care Personnel Registry Investigator Jennifer Baxter observed C.W. in a wheelchair but not in her bed. RHA Howell/Westminster Administrator Kandy John had not seen C.W. in her bed and was

not familiar with her behavior or movements in bed. Rhonda English also was not familiar with C.W.'s movements or behavior in bed. Deborah Foster had observed C.W. in bed but was not familiar with her current movements and behavior in bed around the time of February 15, 2013.

13. C.W. was in a twin bed on February 15, 2013. She previously had been in a different room in a full- or queen-sized bed. (R. Exs. 3 & 4) C.W.'s twin-sized bed was placed in the corner of the room with a window sill at the head and a window sill at the left side of the bed. In her report and at trial, Investigator Baxter stated that the window sill was two inches above the left side rail on the bed and protruded about half an inch over the bed along the left side rail. (R. Ex. 16)
14. On February 15, 2013, Petitioner and Sabrina Jernigan assisted C.W. with her evening shower and hygiene. When assisting C.W. from her shower to bed, Petitioner and Sabrina Jernigan used a two-person lift to transfer C.W. to her bed. (R. Exs. 3-5) C.W.'s life plan at the time specified transfers by a Hoyer lift operated by two staff. (R. Ex. 6) Petitioner and Sabrina Jernigan did not use a Hoyer lift to transfer C.W. on February 15, 2013. After Petitioner and Sabrina Jernigan transferred C.W. to her bed and laid her down vertically on the bed, C.W. was playing around and hit her head on the window sill. C.W. sustained a cut to the left back of her head. (R. Exs. 3-5)
15. Petitioner and Sabrina Jernigan notified staff on call about C.W.'s injury, and LPN Rhonda English came to the facility to assess and treat C.W. Rhonda English and Clinical Coordinator Deborah Foster decided to send C.W. to the hospital for further evaluation and treatment, where she received staples to close her wound. (R. Exs. 3-5, 8, & 9)
16. There were no allegations that Petitioner or Sabrina Jernigan failed to attend to C.W.'s injury or failed to appropriately notify more senior staff associated with the facility. There also was no allegation that Petitioner abused C.W.
17. Deborah Foster conducted an investigation on behalf of RHA. As a result of her investigation, she submitted a 24-hour report and a 5-day report to the Health Care Personnel Registry alleging that Petitioner and Sabrina Jernigan had neglected C.W. by failing to use a Hoyer lift in accordance with her life plan. (R. Exs 10-12)
18. The North Carolina Health Care Personnel Registry ("HCPR") investigates allegations against unlicensed health care personnel working in health care facilities in North Carolina. The allegations investigated by HCPR include, but are not limited to, abuse and neglect. With the exception of a finding of a single instance of neglect, substantiated findings against health care personnel are permanently listed on the HCPR. N.C.G.S. § 131E-256.
19. At all times relevant to this incident, Jennifer Baxter, a Registered Nurse, was employed as an investigator for the HCPR. She is charged with investigating allegations, including abuse and neglect, against unlicensed health care personnel in Guilford County, North

Carolina, among others, and was assigned to conduct the investigation into the allegations against Petitioner. (R. Ex. 16)

20. Upon receipt of the allegations against Petitioner, Investigator Baxter determined that the matter required further investigation. Upon making this determination, Investigator Baxter informed Petitioner by certified letter that an investigation would be conducted regarding the allegations that Petitioner had neglected C.W.
21. Investigator Baxter came to the facility to investigate on March 12, 2013. She did not speak with any staff that usually worked the evening shift where they assisted C.W. with her shower, evening hygiene, and placement in bed. Investigator Baxter attempted to contact Sabrina Jernigan but was unsuccessful. (R. Ex. 16) She spoke with Petitioner by telephone. Petitioner promptly contacted Investigator Baxter the same day that she received a certified letter asking Petitioner to contact Investigator Baxter. Petitioner elected to submit a written statement to Investigator Baxter.
22. As a result of her review of written materials and records obtained from the facility, her interviews and the statements that she obtained or the facility obtained, Investigator Baxter substantiated a finding that Petitioner had neglected C.W. by failing to use a Hoyer lift to transfer C.W. that resulted in an injury to C.W.'s head. (R. Ex. 16)
23. C.W.'s life plan specified use of a Hoyer lift for transfers due to C.W.'s osteoporosis. (R. Ex. 6) C.W.'s life plan previously had provided for use of a two-person lift to assist in transferring C.W. Rhonda English and Clinical Coordinator Foster agreed that a two-person lift can be done safely to transfer C.W.
24. Investigator Baxter did not ask Petitioner whether the injury to C.W.'s head occurred during the two-person lift performed by Petitioner and Sabrina Jernigan or after they had completed the lift and placed C.W. safely in the bed.
25. By certified letter dated April 23, 2013, Investigator Baxter notified Petitioner that the allegations that Petitioner had neglected C.W. had been substantiated and that those findings would be listed against Petitioner on the HCPR. Petitioner was notified of her right to appeal. (R. Ex. 18)
26. Under N.C.G.S. § 131E-256, the North Carolina Department of Health and Human Services ("Department") is required to establish and maintain a health care personnel registry that contains the names of all unlicensed health care personnel working in health care facilities in North Carolina who are subject to a finding by the Department that they abused or neglected a resident in a health care facility, or have been accused of such an act if the Department has screened the allegation and determined that an investigation is warranted.
27. Before presenting any evidence, Petitioner made a motion that the finding of neglect be overturned for lack of evidence of a causal connection between the injury sustained by C.W. and Petitioner's use of a two-person lift rather than a Hoyer lift to assist in

transferring C.W. to her bed. The Undersigned determined that the evidence at trial did not demonstrate neglect by Petitioner and the Health Care Personnel Registry's finding of neglect should be overturned.

28. "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 10A N.C.A.C. 13O.0101(10); 42 CFR § 488.301. This definition requires evidence that the services that were not provided by the accused health care personnel were necessary "to avoid physical harm." The evidence at trial did not establish that failure to use a Hoyer lift to transfer C.W. was necessary to avoid physical harm or that the injury sustained by C.W. was caused by Petitioner's failure to use a Hoyer lift rather than C.W.'s own actions.
29. Petitioner did not present any evidence.

### **CONCLUSIONS OF LAW**

1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter under Chapters 131E and 150B of the North Carolina General Statutes.
2. All parties correctly have been designated, and there is no question as to misjoinder or nonjoinder.
3. As a health care personnel working in a residential facility, Petitioner is subject to the provisions of N.C.G.S. § 131E-256.
4. RHA Howell/Westminster Group Home, 1111 Westridge Road in Greensboro, North Carolina is a group home for developmentally disabled adults and is therefore subject to N.C.G.S. § 131E-256.
5. The preponderance of the evidence in this case shows that on February 15, 2013, Petitioner did not fail to provide goods or services to C.W. that were necessary to avoid physical harm. The preponderance of the evidence does not show that Petitioner's actions or failure to act resulted in physical injury to C.W. or that Petitioner's actions or failure to act created an increased probability of physical harm to C.W. The evidence in this case is that C.W.'s injury occurred after she was placed in bed and released by her caregivers, not during the transfer. The preponderance of the evidence shows that Petitioner did not neglect C.W.
6. Respondent's substantiation of the allegations of neglect against Petitioner is not supported by a preponderance of the evidence.
7. Petitioner satisfied her burden of proving that Respondent substantially prejudiced Petitioner's rights, failed to act as required by law or rule, exceeded its authority and failed to use proper procedure when Respondent substantiated the allegations that Petitioner neglected C.W. at RHA Howell/Westminster, 1111 Westridge Road in

Greensboro, North Carolina, North Carolina, and entered said findings against Petitioner on the North Carolina Health Care Personnel Registry.

8. The Undersigned directs that the Health Care Personnel Registry remove from Petitioner's name any reference to a pending allegation against her on the Health Care Personnel Registry and that the records of the Health Care Personnel Registry reflect that the finding of neglect was not established.

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

### **FINAL DECISION**

Respondent's decision to place a finding of neglect of a resident by Petitioner's name in the Health Care Personnel Registry is not supported by a preponderance of evidence and is REVERSED. Respondent shall note that the finding of neglect by Petitioner was reversed and shall delete any finding from the Registry concerning Petitioner related to this incident. Each party shall pay its own costs.

### **NOTICE**

**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 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 5th day of November, 2013.

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Beecher R. Gray  
Administrative Law Judge