STATE OF NORTH CAROLINA

COUNTY OF LENOIR

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
13 DHR 18454

LAWANDA SUGGS, Petitioner, v. NC DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, HEALTH CARE PERSONNEL REGISTRY, Respondent.	**FINAL DECISION**

THIS MATTER came for hearing before the undersigned, Donald W. Overby, Administrative Law Judge, on May 22, 2014 in the Office of Administrative Hearings in New Bern, North Carolina.

APPEARANCES

For Petitioner: Lawanda Suggs
Pro Se
2217 Ivy Road
Kinston, NC 28501

For Respondent: Bethany A. Burgon
Assistant Attorney General
North Carolina Department of Justice
P.O. Box 629
Raleigh, NC 27602

ISSUE

Whether Respondent deprived Petitioner of property; otherwise substantially prejudiced Petitioner's rights; exceeded its authority or jurisdiction; acted erroneously; failed to use proper procedure; acted arbitrarily or capriciously; or failed to act as required by rule or law when Respondent substantiated the allegation that on or about April 9, 2013 Petitioner, a health care personnel, neglected a resident, KS, by failing to utilize facility authorized restrictive and non-restrictive intervention techniques resulting in the resident's hair braids pulled from her hair, a scratch to the right side of the neck, redness to the right forearm, mental anguish and pain. And whether, on or about April 9, 2013, Petitioner, a health care personnel, abused a resident, KS, by willfully engaging in a physical altercation with the resident resulting in physical harm, mental anguish and pain.

APPLICABLE STATUTES AND RULES

N.C. Gen. Stat. § 131E-256
N.C. Gen. Stat. §150B-23
42 CFR § 488.301
10A N.C.A.C. 13O.0101

EXHIBITS

Respondent's Exhibits 1-10, 13-23, 25, 26 were admitted into evidence. Exhibits 17 – 23 were accorded appropriate weight in that none of the proponents of the statements were in court and available for cross examination.

WITNESSES

For Respondent:	Melissa Gatling Simmons
	Samantha Cannon
	Nancy Gregory
For Petitioner:	Lawanda Suggs

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 matter Petitioner, Lawanda Suggs, was employed as a Health Care Personnel working for Nova Psychiatric Hospital ("Nova"), a health care facility in Kinston, North Carolina and therefore subject to N.C. Gen. Stat. § 131E-256. (T. pp. 8-9)

2. Petitioner completed all required training related to her job responsibilities as a paraprofessional. Petitioner received orientation by Nova when she began her job, and was trained throughout her employment. Petitioner signed a job description for a paraprofessional at Nova, and signed the Nova Healthcare Abuse and Neglect policy. Petitioner learned through her training that she could not abuse or neglect a patient. Petitioner received specific training through North Carolina Intervention ("NCI"), for hold techniques and restrictive interventions. (T. pp. 9-10; Resp. Exhs. 1-5)

3. Petitioner knew that that part of neglecting a patient could involve failing to de-escalate a behavioral situation. Petitioner also knew, and admitted during her testimony, that it was neglect to fail to walk away from an escalated situation when staff could relieve her. She admitted it would be abuse to pull a patients hair, push a patient, and hit a patient. (T. pp. 9-10; Resp. Exh. 2-5)

4. Petitioner was working at Nova on April 9, 2013 in the evening, during the time of the incident with KS. (T. p. 15)

5. Petitioner admitted she was aware that every patient, had a care plan and KS had a specific care plan that described how to handle her behaviors. Petitioner testified that it is customary to give patients a warning when they start exhibiting a behavior. If the warning is not successful, staff are to step away from the patient and let them calm down while maintaining eyesight. (T. p. 40;).

6. Nova houses patients from age 8 to 18, and stay at Nova for anywhere from six months to two years. The majority of patients come from hospitalization, and need to work on behavioral problems like physical aggression, verbal aggression, self-injurious behaviors, oppositional defiance, and other conduct disorders. (T. pp. 42-43)

7. K.S. was admitted to Nova for causing problems in her home and school environment. K.S. had a known propensity to instigate fights, though she rarely participated in the physical altercations. (T. p. 46)

8. On April 9, 2013, at approximately 9:00 pm, Petitioner was attempting to get KS to go to bed, but KS was resisting because she wanted to see the rest of her TV show, which was about to end. Petitioner threatened to write up KS for her behavior, and went to retrieve the paper work in the pod next to the TV area. According to Petitioner, KS started a physical altercation with Petitioner by grabbing Petitioner's hair. Petitioner denied pushing, shoving, or grabbing KS's hair during the altercation. After a brief period of time, Petitioner said she was then removed from the room by a male staff, and proceeded to fill out a report about the incident. (T. pp. 19-22; Resp. Exh. 6)

9. In Petitioner's written statement she reported that KS followed her from the TV area to where the resident data sheets were kept. She attempted to redirect KS from the area because residents were not allowed in that area. In her statement Petitioner said she put KS in a sitting therapeutic wrap; however, during the hearing she admitted that she did not put KS in a sitting therapeutic wrap. Her written statement is also inconsistent with the statement from Samantha Cannon ("Cannon"). Petitioner admits that Cannon was present before and during the incident with KS. (T. pp. 25-26; Resp. Exhs. 6)

10. Though Petitioner initially claimed during her testimony she did not know how KS's braids got pulled out, she later claimed she remembered that another patient K pulled them out earlier in the week. (T. p., 30; Resp. Exhs. 7)

11. At all times relevant Cannon worked for Nova as a paraprofessional; however, at the time of the hearing she no longer works there. Cannon was working on April 9, 2013 when the incident occurred between Petitioner and KS. (T. p. 56; Resp. Exh.)

12. Cannon testified that KS approached her after Petitioner had directed KS to go to bed, and complained Petitioner was being mean to her. Cannon locked arms with KS and started to direct her to her room. Petitioner approached and tried to get hold of KS's other arm. Petitioner and KS were cussing each other. Petitioner grabbed KS's arm, but did not use a therapeutic technique. KS did not want to be touched by Petitioner and started pushing her away. Petitioner continued to grab KS. Cannon saw Petitioner and KS slap, push, and shove each other. Cannon reported KS was grabbing Petitioner's hair and Petitioner had her hand on the back of KS's head, attempting to push her off. Cannon saw Petitioner pulling KS's hair. Cannon described the incident as looking like two girls fighting in a high school fight. (T. pp. 59-64; Resp. Exhs. 15, 16)

13. Cannon attempted to separate the two, but was unable to do so. Both Petitioner and KS fell back onto a couch, but were still entangled in each other's hair. (T. p. 60; Resp. Exh. 15)

14. Neither LaToya Williams ("Williams") nor Darius Fields ("Fields") were present or testified in the contested case hearing; however, their respective statements are consistent with the credible statements and testimony of Cannon, as well as the testimony of Petitioner in part.

15. Williams and Fields entered the common area while the incident was occurring between Petitioner and KS. Fields saw that Petitioner and KS had each other by the hair and saw them fall over the back of the couch. Williams then came in and helped Cannon separate Petitioner and KS. Fields escorted Petitioner from the area. Williams and Cannon calmed KS down, and escorted her back to her room. Williams saw the hair braids on the floor. (T. p. 60, 68; Resp. Exhs. 15, 18, 20)

15. After Petitioner was escorted out of the area, Cannon reported seeing 2 to 4 braids lying on the floor. Cannon also noticed that the back of KS's head was red and she was complaining of soreness in that area. KS had hair braids at the time of the incident. Petitioner did not have hair braids at the time of the incident. (T. pp. 65-66)

16. The night time nurse, Carl Brewer ("Brewer") was not present and did not testify in the hearing. Respondent offers that Brewer assessed KS and found scratches on her arm and red marks on her neck and shoulders. (T. pp. 67-68) This evidence is not corroborated by any other evidence.

17. Melissa Gatling Simmons, ("Simmons") testified at the contested case hearing. Simmons was at all times relevant employed by Nova as a Consumer Affairs Coordinator. On April 10, 2013 KS reported the incident to Simmons, and was visibly upset by what had

happened on April 9, 2013. KS reported that Petitioner was fighting with her like they had been out on the street. (T. p. 48)

18. Simmons performed the facility investigation into the incident between Petitioner and KS. On April 10, 2013 Simmons then completed the Inquiry form, which includes all interviews performed during the investigation, what actions are being taken to protect the patients, and the findings of the investigation. During the investigation Simmons interviewed KS, the Petitioner, Cannon, Simmons also reviewed all written statements made by witnesses . LaToya Williams ("Williams"), and Darius Fields ("Fields"). (T. p. 41-52; Resp. Exh. 10, 15, 17, 19, 23,)

19. Simmons filled out and submitted the 24 hour Initial Report to the Health Care Personnel Registry ("HCPR"), involving the incident on April 9, 2013. (T. p. 47; Resp. Exhs. 9)

20. At the end of her investigation Simmons substantiated the allegations of abuse and neglect against Petitioner. Simmons also submitted an IRIS report to the state that included all documentation and information collected during the facility investigation. (T. p. 22; Resp. Exh. 10, 13)

21. After Simmons turned her investigation results into the Personnel section of Nova, Personnel made the decision to terminate Petitioner's employment for violating Nova's abuse policies and the seriousness of Petitioner's actions. (T. pp. 52-53; Resp. Exhs. 11, 12)

22. The Health Care Personnel Registry Investigation's Branch ("HCPRIB") investigates allegations of abuse, neglect and other allegations against health care personnel in health care facilities. If the allegation is substantiated, the employee will be placed on the Registry. The HCPRIB covers most health care facilities in North Carolina that provide patient care. Accordingly, health care personnel at Nova are covered by the Registry. (T. pp. 75)

23. At all times relevant to this incident, Nancy Gregory ("Gregory") was employed as an investigator for the HCPRIB. She is charged with investigating allegations against health care personnel in the eastern region of North Carolina, including Lenoir County. Accordingly, Nova was in her region and she received and investigated the complaint that Petitioner had abused and neglected Resident L.J. (T. p. 74)

24. After the complaint against Petitioner was received, it was determined it needed further investigation. As part of the investigation, Gregory interviewed Petitioner, Cannon, Williams, Fields and Brewer. She also reviewed the resident's records and took into account the internal investigation conducted by the facility. (T. pp. 74-; Resp. Exhs. 16)

25. On September 11, 2013 and again on September 13, 2013, Gregory interviewed Petitioner. Petitioner told Gregory that she performed a therapeutic wrap on KS, but this was inconsistent with the reports of the other witnesses. Additionally, there was no documentation of a therapeutic wrap being performed on KS on April 9, 2013. If any therapeutic wrap is performed on a patient it is to be documented in the facilities records. (T. pp. 82-84; Resp. Exhs.

7, 8)

26. Gregory interviewed Cannon. Gregory found Cannon to be a credible source, and found that her statements during the interview were consistent with her statement to the facility. (T. p. 79; Resp. Exhs.15, 16)

27. Gregory interviewed Williams. Williams told Gregory that she noticed after the incident KS was missing a few braids, and Williams saw braids on the floor at the scene of the incident. (T. p.80; Resp. Exh.18)

28. Gregory interviewed Fields. Gregory determined that Fields was present for part of the incident, and saw Petitioner and KS pulling each other's' hair. (T. p. 81; Resp. Exh.20)

29. Gregory also reviewed the investigations performed by the Department of Social Services ("DSS"), and the Department of Health Safety Regulation ("DHSR"). (T. p. 87)

30. Gregory took Petitioner's statement into consideration and viewed all the information together. Gregory found the statements of Cannon to be credible and consistent. Gregory wrote an investigation report which documented the conclusion and substantiated the allegations of neglect and abuse against Petitioner. (T. pp. 85-89; Resp. Exh. 25)

31. Neglect is defined as "a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." Gregory determined Petitioner neglected resident KS of Nova by failing to utilize facility authorized restrictive and non-restrictive intervention techniques resulting in the resident's hair braids pulled from her hair, a scratch to the right side of the neck, redness to the right forearm, mental anguish and pain. (Resp. Exh. 25)

32. Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." Gregory determined Petitioner abused resident KS of Nova by willfully engaging in a physical altercation with the resident resulting in physical harm, mental anguish and pain. (Resp. Exh. 25)

33. Petitioner was notified by letter that a finding of neglect and a finding of abuse would be listed against her name in the Health Care Personnel Registry ("HCPR"). Petitioner was further notified of his right to appeal. (T. p. 91; Resp. Exh. 26)

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. 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 or neglected a resident in a health care facility.

4. As a health care personnel working in a health care facility, Petitioner is subject to the provisions of N.C. Gen. Stat. § 131E-256.

5. Nova Psychiatric Hospital of Kinston 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 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 or about April 9, 2013, Petitioner abused a resident (KS) by willfully engaging in a physical altercation with the resident resulting in physical harm, mental anguish and pain.

8. "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. 13O.0101, 42 CFR § 488.301.

9. On or about April 9, 2013, Petitioner neglected a resident (KS) by failing to utilize facility authorized restrictive and non-restrictive intervention techniques resulting in the resident's hair braids pulled from her hair, a scratch to the right side of the neck, redness to the right forearm, mental anguish and pain

10. Respondent's decision to substantiate this allegation of abuse and the allegation of neglect against the Petitioner is supported by a preponderance of the evidence. Therefore, Respondent did not deprive Petitioner of property; otherwise substantially prejudice Petitioner's rights; exceed its authority or jurisdiction; act erroneously; fail to use proper procedure; act arbitrarily or capriciously; or fail to act as required by rule or law by placing a substantiated finding of abuse and neglect against Petitioner's name on the Health Care Personnel 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 neglect and abuse at Petitioner's name on the Health Care Personnel Registry should be **UPHELD**.

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 15th day of August, 2014.

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Donald W. Overby
Administrative Law Judge