STATE OF NORTH CAROLINA	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF MONTGOMERY	13 DHR 18668

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

This contested case was heard before the undersigned, Julian Mann III, Chief Administrative Law Judge, on February 24, 2014 and February 25, 2014 in the Office of Administrative Hearings, Guilford County Courthouse, in High Point, North Carolina.

APPEARANCES

For Petitioner: David LeGrand
Pro Se
PO Box 1022
Mount Gilead, NC 27306

For Respondent: June S. Ferrell
Special Deputy 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 September 1, 2013 David LeGrand, a Health Care Personnel, abused L.J. by confining a resident in a closet resulting in mental anguish, and neglected L.J by failing to follow the person centered plan for a resident during a behavior and confined the resident in a locked closet resulting in mental anguish.

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 1-24 were admitted into evidence.

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WITNESSES

For Respondent:	Sabrina Clark Letisha Calloway Genita McBride Barry Thomas Owen Kathy Moshman
For Petitioner:	David LeGrand

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 Petitioner, David LeGrand, was employed as a Health Care Personnel working for Monarch-Myrtlewood ("Myrtlewood") Group Home, a health care facility in Mount Gilead, North Carolina and therefore subject to N.C. Gen. Stat. § 131E-256. (T. pp. 13; Resp. Exh. 7)

2. Petitioner completed all required training related to his job responsibilities as a behavior specialist. Petitioner initialed and signed the job description for behavior specialist at Myrtlewood, which included "supporting people who have been identified as highly aggressive." Petitioner signed a Certification of Completion for Myrtlewood's Orientation. As part of the orientation, Petitioner attended recertification training on the Prevention and Alternatives to Restrictive Interventions, where he learned skills for assessing individual risks

for escalating behavior and communication strategies for diffusing and de-escalating potentially dangerous behavior. Petitioner received training about abuse, neglect and exploitation. (T. pp. 20-34; Resp. Exhs. 1, 2, 3)

3. Petitioner was trained on reporting abuse, neglect and exploitation, and Petitioner understood that this was part of his duties as an employee of Myrtlewood. (T. pp. 33; Resp. Exh. 3)

4. Petitioner worked at Myrtlewood on September 1, 2013 from 8:00 am to 8:00 pm, during the time of the incident with L.J. Grace Thompson ("Thompson"), Barry Owens ("Owens"), and Leshaunda Horne ("Horne"), worked at Myrtlewood on September 1, 2013. (T. pp. 13-14; Resp. Exh. 5)

5. L.J. was 44 years old at the time of the incident. L.J has an I.Q. of 36, has Severe Mental Retardation and Autism, and operates at the level of a 5 year old. Although L.J is verbal, she rarely ever speaks. (T. pp. 104-113; Resp. Exh. 18)

6. In the Behavior/Life Skills plan for L.J. staff are to verbally redirect her when she is having an inappropriate behavior. It is documented in her behavior plan that L.J. will have inappropriate behaviors often, but responds well to redirection. All of the staff working on September 1, 2013 were aware and had been trained on L.J.'s Behavior Skills plan. (Resp. Exh. 18, 19, 23)

7. Petitioner was generally assigned to B.G., and was assigned to work with B.G. on September 1, 2013. (T. p. 21; Resp. Exh. 5)

8. On June 27, 2012, Petitioner received person specific training on L.J. (Resp. Exh. 23)

9. On the morning of September 1, 2013, L.J was exhibiting a high incidence of inappropriate behaviors. L.J. walked around in inappropriate night clothes and had continuously fouled her room. When L.J. left her room she was redirected several times to return to her room and put on a house coat. L.J. walked in and out of rooms and picked up and rearranged items. Staff continuously redirected her throughout the day. (T. pp. 15-18, 134; Resp. Exhs. 5, 13, 14, 15)

10. After lunchtime Thompson called for Petitioner to come assist her in picking up L.J. from the floor in the hallway. Petitioner assisted Thompson by lifting L.J. off of the floor. Petitioner told L.J. that if she did not start behaving she would get a visit from a witch. (T. pp. 18-19, 28; Resp. Exhs. 4, 10)

11. Later that afternoon L.J. was confined in a hallway closet. When L.J. would say the word "bed," L.J. was let out of the closet. Petitioner and others employed scare tactics to get L.J. to behave. (Resp. Exh. 7)

12. Owens reported hearing yelling, and heard L.J. say "let me out." Owens was in the living room at the time, and did not and could not physically see the incident. (T. p. 142; Resp. Exhs. 6, 14)

13. In the afternoon of September 1, 2013, Horne reported seeing Petitioner put on a Halloween mask, and say to L.J. "If you don't stop cutting up and going to the trash can, the boogie man is going to get you." This Halloween mask is regularly kept in the record room. Another Halloween mask known as the "wig" was found in B.G.'s room. Petitioner is regularly assigned to B.G. (Resp. Exhs. 8, 15, 22)

14. Owens attempted to send an email about the incident to Brian Stone, ("Stone") Operations Director, but the message did not reach Stone. After his shift ended on September 1, 2013' Owens called Peggy Tehune, the owner and operator of Monarch, the parent company for Myyrtlewood, and reported the incidents with L.J. (T. p. 139; Resp. Exh. 17)

15. Sabrina Clark ("Clark") a Qualified Professional, Letisha Calloway ("Calloway") a Qualified Professional, and Genita McBride ("McBride") an Operations Manager with Monarch, were all called on the night of September 1, 2013 to report to Myrtlewood and conduct an investigation concerning the incident that occurred with L.J. (T. pp. 61-63, 92-93, 117-119; Resp. Exh. 16)

16. Clark, Calloway and McBride interviewed Petitioner, Thompson, Owens and Horne at Myrtlewood on the night of September 1, 2013. Each member of staff was directed to write a statement accounting for the day's events, and then each was questioned about the incident. (T. pp. 64-89; Resp. Exhs. 5, 6, 7, 8, 9)

17. While being interviewed by Clark, Calloway and McBride, Petitioner admitted that he used the witch "scare tactic" with resident L.J. sometime before lunch. Petitioner went on to say that some of the staff use the term "witch" to calm L.J. down. Petitioner denied having any knowledge of a Halloween mask, or of confining L.J. in a closet. (Resp. Exh. 5)

18. During Thompson's facility interview on September 1, 2013, she reported that all staff on duty that day knew L.J. had been confined in the closet. Thompson alleged that after lunch she and David put L.J. in the closet for a few seconds to scare her, because she was exhibiting inappropriate behaviors. Petitioner, in his testimony and interview specifically denied Thompson's allegations. Thompson was not present at the hearing, and she did not testify. (T. pp 235, 274-275; Resp. Exhs. 7, 13)

19. A mask was found by Calloway and McBride in the record room, and a second mask was found in the dresser drawer of B.G.'s room. Petitioner was assigned to B.G. (T. p.107; Resp. Exh. 9)

20. On September 2, 2013 Richard Evers ("Evers") of Montgomery County Adult Protective Services was notified of the incident. (Resp. Exh. 9, 22)

21. After the facility investigation was completed, Calloway recommended Petitioner be terminated, and substantiated the allegation of abuse. Petitioner, Thompson, and Horne were all terminated from employment with Myrtlewood. (T. p. 98; Resp. Exhs. 9, 10)

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 Myrtlewood are covered by the Registry. (T. pp. 166-167)

23. Kathy Moshman ("Moshman") was employed as an investigator for the HCPRIB. She is charged with investigating allegations against health care personnel in the south central region of North Carolina. Accordingly, Myrtlewood was in her region and she received and investigated the complaint that Petitioner had abused and neglected Resident L.J. (T. p. 166)

24. As part of the investigation against Petitioner, Moshman interviewed Petitioner, Thompson, Horne, Calloway, Clark and McBride. She also reviewed the resident's records and took into account the internal investigation conducted by the facility. (T. pp. 171, 176-178; Resp. Exhs. 1-7 and 9-16)

25. On November 19, 2013, Moshman interviewed Petitioner at the Montgomery County Library. Petitioner admitted to Moshman that other staff at the facility had informed him L.J. had a fear of witches. Petitioner also admitted that scaring a resident was not an acceptable method to redirect a resident. Petitioner did say that he mentioned to L.J. that she might get a visit from a witch, but he did not believe this was threatening. Petitioner denied ever seeing either of the Halloween masks that were found in the facility. (Resp. Exh. 13)

26. On November 13, 2013, Moshman interviewed Owens at Myrtlewood. Owens reported that he saw and heard resident L.J. exhibiting behaviors all day on September 1, 2013. He reported "hearing" someone holding the door shut while L.J. was in the closet. Owens also told Moshman he heard both the Petitioner and Thompson refer to the Halloween mask while talking with L.J. (T. p. 171; Resp. Exh. 14)

27. On December 10, 2013, Moshman interviewed Horne over the phone. Horne informed Moshman that L.J.'s behaviors reached a level on September 1, 2013, where staff should have called the home manager of Myrtlewood. Horne also admitted that she should have called the home manager when she saw Petitioner put the Halloween mask on, and tell L.J. the boogeyman would come get her. Horne confirmed that she knew about L.J.'s Behavior plan, and had read it. (T. p. 171; Resp. Exh. 15)

28. On November 13, 2013, Moshman attempted to interview resident L.J., but L.J. was non-responsive to questioning and mimicked phrases back to Moshman. (Resp. Exh. 19)

29. On November 14, 2013, Moshman spoke to Evers regarding his investigation into

the incident with Petitioner. Evers informed Moshman he did start an investigation into the incident, but because the facility had already fired the individuals involved it was unsubstantiated. Evers told Moshman that he spoke with L.J.'s father and sister who confirmed she had had a fear of masks and Halloween costumes her whole life, and that the facility was aware of this. (T. p. 184; Resp. Exh. 20)

30. Moshman used a reasonable person standard to determine that confining L.J. in the closet resulted in mental anguish. A reasonable person standard is used when determining whether a resident who is nonverbal or unable to express themselves, has suffered mental anguish or pain. It is not necessary that signs of physical abuse be found on the resident, the mere threat to someone with severely diminish capacity is enough to cause that resident mental anguish. (T. pp. 181, 188-190; *Allen v. NCDHHS*, 155 N.C. App. 77, 85, 88; 575 S.E.2d 565, 570, 572 (2002).

31. Neglect is defined as "a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." Moshman testified Petitioner neglected resident L.J. of Myrtlewood by putting on a witch's mask to frighten L.G. as a means to redirect L.G. (Resp. Exh. 23) (T. pp. 202, 203)

32. Petitioner was notified by letter that a finding of neglect and a finding of abuse would be listed against his name in the Health Care Personnel Registry ("HCPR"). Petitioner was further notified of his right to appeal. (Resp. Exh. 24)

33. Petitioner denies threatening resident L.J. and indicated that he never confined the resident in a closet. (T. p.41-43, 53; Resp. Exhs. 5, 13)

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. Monarch-Myrtlewood of Mount Gilead 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 September 1, 2013, the evidence is insufficient to conclude by the preponderance of the evidence that Petitioner abused a resident (L.J.) by confining the resident in a closet resulting in mental anguish.

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 September 1, 2013, Petitioner neglected a resident (L.J) by failing to follow the person centered plan for the resident during a behavior in attempting to redirect L.J. by scaring or frightening L.G. by talking about witches and putting on a witch's mask.

10. Respondent's decision to substantiate 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 neglect against Petitioner's name on the Health Care Personnel Registry. A substantiation of abuse is not justified as not proven by the preponderance of the evidence.

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, but not abuse, at 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 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, date on the Certificate of Service attached to this Final Decision. N.C. **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**. 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 1st day of August, 2014.

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Julian Mann III
Chief Administrative Law Judge