STATE OF NORTH CAROLINA | IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF WAYNE | 13 DHR 19156

Victor Horn, Petitioner, v. Department of Health and Human Service Division of Health Service Regulation, Respondent.	)	**AMENDED FINAL DECISION**

The above-captioned case was heard before the Honorable Donald W. Overby, Administrative Law Judge, on July 18, 2014 in Raleigh, North Carolina and on August 28, 2014 in Goldsboro, North Carolina. The Final Decision issued on January 14, 2015 is amended as follows:

APPEARANCES

FOR PETITIONER: Glenn A. Barfield
Haithcock, Barfield, Hulse & Kinsey, PLLC
PO Drawer 7
Goldsboro, North Carolina 27533-0007

FOR RESPONDENT: Derek L. Hunter
Assistant Attorney General
NC Department of Justice
PO Box 629
Raleigh, NC 27602-0629

EXHIBITS

Admitted for Petitioner:

Exhibit Number	Description
1	Annual Psychiatric Assessment of M.V., Revised February 6, 2013 Noting Reason for Commitment at Cherry Hospital
2	Progress Note, Treatment Team Review Notes, Other Documents Summarizing Treatment Plan for M.V. Dated October 31, 2013
3	Falls Risk Reassessment of M.V. Dated October 31, 2013
4	Progress Notes, Flow Sheets, and Nursing Assignments, for the Following Dates: June 15, 2013, June 16, 2013, June 19, 2013, June 23, 2013, September 29, 2013, October 30, 2013.
5	CPI Training Materials

6	Cherry Hospital Precautions and Standard Accountability
7	Precaution Flow Sheet and Nursing Assignment Sheet Dated October 14, 2013
8	Witness Statement Victor Horn
**9	Witness Statement Milton Edmundson
**10	Witness Statement Beverly Cook
**11	Witness Statement Geraldine Brown
12	Witness Statement Jeannie Jackson
**13	Witness Statement Marilyn Aughtry
**14	Witness Statement M.V.
**15	Initial Report of Abuse, Neglect, Exploitation
**16	Management Investigation Report
**17	Registry Reports
**18	Registry Interview Notes
**19	Interview of Patient Advocate Neal Weeks by Nancy Gregory
**20	Interview of Karen Tyson by Nancy Gregory
**21	Cherry Hospital Internal Investigation Report
22	Cherry Hospital Video Surveillance of Alleged Incidents of Abuse
**23	Transcript of Testimony Given at the Division of Employment Security Appeals Hearing
24	Cherry Hospital Clinical Care Plan: Abuse/Neglect/Exploitation and Other Rights Infringements
25	Cherry Hospital Clinical Care Plan: Rapid Response – Behavioral Emergencies
26	Cherry Hospital Code of Conduct APM – Section IV
27	Competency Assessment Tool for Victor Horn

(** To the extent that Petitioner's exhibits include hearsay statements of persons who did not testify in person at the hearing, such statements within Petitioner's exhibits are not admitted for the truth of such statements, but are instead admitted for non-hearsay purposes.)

Admitted for Respondent:

Exhibit Number	**Description**
1	HCPR 24-Hour Initial Report
2	HCPR 5-Working Day Report
**3	HCPR Investigation Letter
4	Cherry Hospital Code of Conduct
5	Cherry Hospital Clinical Care Plan (Precautions and Standard Accountability)
6	Cherry Hospital Clinical Care Plan (Falls Prevention and Management Program)
7	Cherry Hospital Clinical Care Plan (Abuse/Neglect/Exploitation/Rights Infringements)
8	Cherry Hospital Clinical Care Plan (Restrictive Interventions – Behavioral)

**11	Jeannie Jackson's Interview (HCPR)
**12	Karen Tyson's Interview (HCPR)
**13	Internal Investigation's Summary Report (Cherry Hospital)
**14	Neal Weeks' Interview (HCPR)
**16	Victor Horn's Interview (HCPR)
17	Victor Horn's Written Statement (Cherry Hospital)
**18	Resident's Information and Observation Form (HCPR)
**19	HCPR Investigation Conclusion Report (Abuse)
**20	HCPR Investigation Conclusion Report (Neglect)
**21	HCPR Substantiation Letter and Entry of Findings
22	Cherry Hospital Video Surveillance of Alleged Incidents of Abuse

(** To the extent that Respondent's exhibits include hearsay statements of persons who did not testify in person at the hearing, such statements within Respondent's exhibits are not admitted for the truth of such statements, but are instead admitted for non-hearsay purposes.)

WITNESSES

Called by Petitioner: Victor Horn
Alok Uppal, MD

Called by Respondent: Jeannie Jackson
Neil Weeks
Nancy Gregory

ISSUES

The sole issue for consideration is whether Respondent acted erroneously, arbitrarily, or capriciously when it found that on October 14, 2013 Petitioner neglected and/or abused M.V., a patient resident in Cherry Hospital, and consequently placed his name in the Health Care Registry pursuant to G.S. 131E-256(a)(1)(a).

ON THE BASIS of careful consideration of the sworn testimony of witnesses presented at the hearing, documents received and admitted into evidence, and the entire record in this proceeding, the Undersigned makes the following Findings of Fact. In making these Findings, the Undersigned has weighed all the evidence and has assessed the credibility, including, but not limited to, the demeanor of the witness; any interest, bias or prejudice the witness may have; the opportunity of the witness to see, hear, know, and remember the facts or occurrences about which the witness testified; whether the testimony of the witness was reasonable; and whether such testimony is consistent with all other believable evidence in the case.

FINDINGS OF FACTS

1. The parties received notice of hearing more than 15 days prior to the hearing, and each stipulated on the record that notice was proper.

2. The Health Care Personnel Registry is established and maintained by Respondent NCDHHS pursuant to G.S. 131E-256.

3. Pursuant to G.S. 131E-256(b)(7), Cherry Hospital is a health care facility as that term is defined in G.S. 122C-3(14)(f).

4. On October 14, 2013, Petitioner Victor Horn was employed by Respondent as a Health Care Technician ("HCT") assigned to Unit Woodard 1 West at Cherry Hospital.

5. G.S. 131E-256(a)(2) requires Respondent to enter into the Healthcare Personnel Registry the name of any healthcare personnel working in healthcare facilities in North Carolina who have been accused of the neglect or abuse of a resident in a healthcare facility.

6. G.S. 131E-256(a) requires facilities such as Cherry Hospital to report all allegations of such abuse or neglect of residents to the Respondent.

7. On October 15, 2013, Nurse Clinical Manager Karen Tyson signed and transmitted to the Respondent a "24 Hour Initial Report" alleging that Mr. Horn pushed resident M.V. to the floor, scratching M.V.'s hand and knee. (Respondent's Exhibit 1)

8. On October 17, 2013, Ms. Tyson signed and transmitted to Respondent a "Five Working Day Report" with allegations against Mr. Horn of resident abuse and resident neglect, stating the location of the incident as "Woodard 1 West men's bathroom and hallway" and describing the incident as "Mr. Horn accused of pushing patient to the floor, causing minor injuries". (Respondent's Exhibit 2)

9. The Five Working Day Report indicated that Cherry Hospital had investigated and "substantiated" these allegations.

10. On October 23, 2013, Respondent gave Mr. Horn written notice that it had entered his name into the Healthcare personnel registry and indicated that it would conduct an investigation of the following allegations: "On or about October 14, 2013 you abused a resident at Cherry Hospital; on or about October 14, 2013 you neglected a resident at Cherry Hospital". (Respondent's Exhibit 3)

11. The notice included a statement of Mr. Horn's right to contest the listing of allegations by filing a Petition for a Contested Case Hearing with the Office of Administrative Hearings.

12. Mr. Horn properly and timely filed his Petition for Contested Case with the Office of Administrative Hearings on November 12, 2013.

13. Mr. Horn filed an Amended Petition for Contested Case Hearing on January 8, 2014.

14. The Petition and the Amended Petition were filed pursuant to G.S. 131E-256(d1), allowing healthcare personnel to contest the placement in the Healthcare Registry of information regarding accusations made, but not yet substantiated, against the healthcare personnel.

15. The Respondent began its investigation into the allegations against Mr. Horn on October 23, 2013. (Respondent's Exhibit 19, p.1; Respondent's Exhibit 20, p.1)

16. Healthcare Personnel Investigator Nancy Gregory conducted the investigation. On May 5, 2014 she signed two "Investigation Conclusion Reports" (the "ICRs"), one regarding the allegation that Mr. Horn abused M.V. (Respondent's Exhibit 19) and the other regarding the allegation that Mr. Horn neglected M.V. (Respondent's Exhibit 20).

17. Ms. Gregory's first ICR "substantiated" the allegation that Mr. Horn abused M.V. "by willfully using improper and unauthorized physical interventions, resulting in physical harm" (Respondent's Exhibit 19, pp.1, 22) (T.pp. 238-242). She concludes that "There is credible evidence to substantiate the allegation that Victor Horn abused the resident, (M.V.) by willfully using improper and unauthorized physical interventions to manage (M.V.)'s aggressive behavior". (Respondent's Exhibit 19, p. 22)

18. Ms. Gregory relied upon the definition of "abuse" as: "the willful infliction of injury…with resulting physical harm, pain or mental anguish," which she articulated in her Investigation Conclusion Report. (Respondent's Exhibit 19, p. 22, T. pp. 240, 262-265) This definition is not the same definition used by Cherry Hospital as articulated in its Clinical Care Plan. (Respondent's Exhibit 7, p. 30)

19. Ms. Gregory's second ICR "substantiated" the allegation that Mr. Horn had neglected M.V. "by failing to utilize facility approved behavioral interventions, and failing to report that the resident had fallen, resulting in physical harm" (Respondent's Exhibit 20, pp. 1, 20). She concluded that "There is credible evidence to substantiate the allegation that Victor Horne neglected the resident, (M.V.) by failing to use facility approved behavioral interventions with (M.V.) during the incidents, failing to report the resident's behaviors, failing to report the resident's falls, and failing to ensure that (M.V.) received a physical assessment by the nurse resulting in risks that physical harm will occur." (Respondent's Exhibit 20, p. 20)

20. Ms. Gregory relied upon the definition of "neglect" as: "the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness," which she articulated in her Investigation Conclusion Report. (Respondent's Exhibit 20, p. 20) This definition is not the same definition used by Cherry Hospital as articulated in its Clinical Care Plan. (Respondent's Exhibit 7, p. 31)

21. G.S. 131E-256(a)(1) requires the Respondent to enter into the Healthcare Registry the names of all healthcare personnel working in healthcare facilities in North Carolina who have been subject to findings by the Respondent of neglect and/or abuse of a resident in a healthcare facility.

22. G.S. 131E-256(d1) provides that "healthcare personnel who have filed a petition contesting the placement of information in the Healthcare Personnel Registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation."

23. Patients housed and maintained in Woodard 1 West at the relevant times were acutely mentally ill, psychotic and aggressive. (T.pp. 32, 164, 178)

24. On October 14, 2013, M.V. was a mental health patient housed and maintained on Woodard 1 West. (Petitioner's Exhibits 1-4, Respondent's Exhibits 19 and 20, T.pp. 23-24, 31-32, 44-45, 162-163)

25. M.V. was at that time involuntarily committed to Cherry as a "House Bill–95" detainee, having been charged with murdering a female on December 22, 2003 while residing in a group home for which crime he had been declared and remained incompetent to stand trial. (Petitioner's Exhibit 1, T.pp. 31-33, 163, 223-224)

26. M.V.'s primary diagnosis was schizophrenia, paranoid type. (Petitioner's Exhibits 1-4, T. pp. 33, 163-164)

27. M.V. was delusional and hallucinatory, frequently believing that other patients and staff were the devil, whom he was compelled to try to kill. (Petitioner's Exhibits 1-4, T. pp. 33, 37, 163-164)

28. M.V. had frequently assaulted or attempted to assault other patients and staff, including prior attacks on Petitioner. (Petitioner's Exhibits 1-4, T. pp. 25-26, 33, 87-88, 163-164)

29. M.V. had a documented history of falling, which included occasions when he was trying to assault others. M.V. was on fall precautions and aspiration precautions. (Petitioner's Exhibits 1-4, T. pp. 25-26, 214)

30. Dr. Alok Uppal was M.V.'s treating psychiatrist. (T.p. 162).

31. Dr. Uppal testified that M.V. was generally delusional and experienced hallucinations, for which medications had little effect (T.p.164). M.V. would hallucinate that he saw the devil in others and, believing these persons to be possessed, he would attack them (T. pp. 164-165). M.V. frequently attacked peers or staff (T. pp. 163-167), and "[w]hen he get violent in response to his internal stimuli he, is pretty much very active. He is slightly obese, but he is very strong. And so obviously he charges because the—that is one reason about the falls." (T.p. 167)

32. The allegations against Mr. Horn arise from two separate incidents occurring between approximately 6:50 AM and 7:10 AM on October 14, 2013. (Respondent's Exhibits 19 and 20, Petitioner's Exhibit 22)

33. The first incident occurred in a bathroom beginning at approximately 6:51 AM.

34. As to that incident Respondent investigated an allegation that Mr. Horn "pushed [M.V.] to the floor … causing minor injuries. (Respondent's Exhibit 2)

35. At that time, Mr. Horn was not assigned any direct patient monitoring duties, but instead was assigned duties in the general maintenance of the unit, including collecting soiled linens and cleaning bathrooms. (T. pp. 30-31)

36. As to this first incident, Mr. Horn testified (T. pp. 45-54, 91-95, 109-122, 138-144) as follows:

> He was in the bathroom cleaning up when M.V. entered, followed by Mr. Edmunson. M.V. immediately came at him aggressively, swinging at him with closed fists. Mr. Horn used or attempted to use techniques referred to by Mr. Horn and other witnesses as "CPI" or "NCI" techniques. (T. pp.47-52, 107-109, 113, 122, 146, 207-208) Mr. Horn was trained to employ those techniques when being assaulted by a patient, including attempting to maneuver away and attempting to catch M.V.'s fist with his hands. M.V. was between Mr. Horn and the exit, restricting his ability to get away from M.V.. Mr. Horn was backing away and trying to catch and block M.V.'s punches, while M.V. kept coming at him. Mr. Horn was not able to avoid some of the punches striking him on the hands and arms. Any efforts by Mr. Edmundson, if indeed there were any efforts at all, to re-direct M.V. were ineffective. At some point M.V. missed on one of his swings, and started to slip or lose his balance. Mr. Horn was then able to grab M.V.'s body and ease him to the floor. Mr. Horn asked M.V. if he was alright and if he wanted Mr. Horn to help him back up. M.V. told Mr. Horn to leave him alone. Mr. Horn collected his linen cart and exited the bathroom. He did not observe M.V. sustain any injury.

37. On October 14, 2013, Milton Edmundson, a Health Care Technician also employed by Cherry Hospital on Unit Woodard 1 West, was assigned "1:1 observation" of M.V. (T. pp. 46, 75-81, 214, 260)

38. This meant that Mr. Edmundson was assigned to continuously stay physically very close to M.V., to continuously supervise, monitor and document M.V.'s activities, to be responsible for M.V.'s safety, and to interact with M.V. in an attempt to direct M.V.'s behaviors away from aggression against others. (T. pp. 46, 65-66, 75, 78-81, 99-103, Respondent's Exhibit 5)

39. During the Respondent's investigation, Mr. Horn consistently denied that he willfully or intentionally caused M.V. to go to the floor in the bathroom, other than his attempt to ease M.V. to the floor once M.V. had slipped and was otherwise going to fall to the floor. (Petitioner's Exhibit 16, 17; Respondent's Exhibits 19, 20)

40. There is no evidence that Mr. Edmundson attempted to do anything.

41. Mr. Horn, Mr. Edmundson, Nurse Geraldine Brown, and M.V. were the only eyewitnesses to what occurred in the bathroom between M.V. and Mr. Horn. (Petitioner's Exhibit 22, T. pp. 45-56, 69-71, 83-96, 115-122) Mr. Edmundson, M.V., nor Ms. Brown testified for either party, thus Petitioner Mr. Horn was the only eyewitness to the events to testify under oath in this contested case hearing.

42. Some of the interaction between Mr. Horn, M.V., and Mr. Edmundson in the bathroom was captured by Respondent's video surveillance camera system. (Petitioner's Exhibit 22)

43. A video camera located in the hallway outside the bathroom had a direct view of the entrance to the bathroom and of a portion of the front of the bathroom. (Petitioner's Exhibit 22)

44. The Undersigned viewed the video recorded by that surveillance camera multiple times during the course of the hearing while it was being used to illustrate or explain the testimony of several persons testifying as witnesses. During the first day of the hearing, the Undersigned and the witnesses were able to view the video on the video system installed in the hearing room at OAH in Raleigh, North Carolina, and the Undersigned watched the video both on the monitor at the bench as well as on the large screen monitor located to the left of the witness box. When the hearing resumed in Goldsboro, the Undersigned was able to view the video on a large projection screen set up in the courtroom.

45. The undersigned finds that the video playback system installed in the courtroom at the Office of Administrative Hearings provides the best picture clarity and resolution as is reasonably available and notes that the first day of the hearing was set in Raleigh instead of Goldsboro at the request of Respondent for the purpose of utilizing the video playback system at OAH.

46. The video was viewed multiple times, in real time and in slow motion, backwards and forwards.

47. The video clearly shows Mr. Horn entering the bathroom pushing a laundry cart, passing through towards the rear of the bathroom, and out of view of the video camera. (Petitioner's Exhibit 22)

48. The video then clearly shows M.V. and Mr. Edmundson entering the bathroom and moving towards the back of the bathroom. For a few seconds, the video camera provides a direct view of the back of M.V. and a part of Mr. Edmundson, during which time M.V. appears to move backwards and forwards; thereafter he moves forward out of direct view of the camera. (Petitioner's Exhibit 22)

49. Thereafter the camera has no direct view of the incident or interaction between Mr. Horn and M.V. (Petitioner's Exhibit 22)

50. The camera has a direct view of several mirrors on the wall on the left side of the bathroom as one would enter, which appear to be hung on the wall above several sinks attached to the wall. (Petitioner's Exhibit 22)

51. In the mirrors, the video very briefly shows Mr. Horn and M.V., and appears to show M.V. going downward towards the floor. (Petitioner's Exhibit 22)

52. From the video alone, it is not possible to determine how or why M.V. went downward towards the floor. (Petitioner's Exhibit 22)

53. Mr. Horn's sworn testimony and the video provided the only direct evidence offered by either party regarding the incident in the bathroom. Respondent's witnesses relied on statements of persons who did not testify in this hearing and thus were not subject to examination and cross-examination. Those hearsay statements are given little to no weight.

54. Some of Respondent's witnesses also testified from their view of the video which this finder of fact viewed many times and found to be sufficiently clear to judge the events at issue. This finder of fact's view of the video is often inconsistent with the view of some of those witnesses, and therefore finds those accounts to not be credible.

55. The undersigned finds Petitioner's testimony regarding the incident in the bathroom to be credible and believable.

56. M.V. losing his balance and beginning to fall before Mr. Horn caught him was consistent with his history of falling while attempting to attack others as testified to by Dr. Uppal.

57. Mr. Horne did not push M.V. to the floor in the bathroom, or otherwise willfully, intentionally, or by other than accidental means cause or contribute to M.V. going to the floor. There is no credible evidence of how Mr. Horn failed to use the approved behavioral interventions or what he could have done differently. Mr. Horn did not fail to utilize facility approved behavioral interventions.

58. The second incident investigated by Respondent occurred approximately 10 minutes later in a hallway where M.V. again attacked Mr. Horn. (Petitioner's Exhibit 22, T. pp. 55-65, 71-74, 123-139, Respondent's Exhibit 19-20)

59. As to this second incident, Mr. Horn testified (T pp. 56-65, 73-74, 123-138) as follows:

> He went into the linen room as Betty Cook, another healthcare technician, was coming out of that room with her assigned patient. Mr. Horn put some things away and came out of the linen room. He was immediately confronted by M.V., who attacked him swinging his fists. Mr. Edmundson was somewhere behind M.V. and again did practically nothing and was ineffective in re-directing M.V. from his attempt to assault Mr. Horn. Mr. Horn put his arm up to block M.V.'s punches and again attempted to use the CPI techniques he had been taught, including trying to grab M.V.'s hand as M.V. was swinging and trying to move away from M.V. He tried to move backwards away from M.V., but M.V. grabbed ahold of him. He tried to get his hand released so he could get ahold of M.V.'s hand. As he moved backwards away from and to the side of M.V, M.V. went down to the floor. Mr. Horn did not observe M.V. sustain any injury. At that point, consistent with his CPI training, Mr. Horn walked away so as to put some distance between himself and M.V.

60. Petitioner testified that he did not willfully or intentionally cause or contribute to M.V. falling in the hallway. (T. pp. 56-65, 73-74, 123-138)

61. From the video, it appears that M.V. lost his balance as Petitioner is backing up in an attempt to get away from M.V. It does not appear from the video that Petitioner caused M.V. to fall. Mr. Edmundson and Ms. Cook are both standing immediately where the incident took place. There is no evidence that Mr. Edmundson or Ms. Cook attempted to do anything to intervene or help in any way.

62. During the Respondent's investigation, Mr. Horn consistently denied that he willfully or intentionally caused or contributed to M.V. falling in the hallway. (Petitioner's Exhibit 16, 17; Respondent's Exhibits 19, 20)

63. The only eyewitnesses to this incident were M.V., Mr. Horn, Mr. Edmundson, and Betty Cook. (Petitioner's Exhibit 22, T.pp. 56-65, 73-74, 123-126, 243-258, Respondent's Exhibit 19-20) Mr. Edmundson, M.V., nor Ms. Cook testified for either party at the hearing; thus Petitioner Mr. Horn was the only eyewitness to the events to testify under oath in this contested case hearing.

64. Respondent's witnesses relied on statements of persons who did not testify in this hearing and thus were not subject to examination and cross-examination. Those hearsay statements are given little to no weight.

65. Mr. Horn's sworn testimony and the video provided the only direct evidence offered by either party regarding the incident in the bathroom.

66. Some of Respondent's witnesses also testified from their view of the video which this finder of fact viewed many times and found to be sufficiently clear to judge the events at issue. This finder of fact's view of the video is often inconsistent with the view of some of those witnesses, and therefore finds those accounts to not be credible.

67. The incident in the hallway was captured by a different video camera from the one that captured the view of the bathroom incident. (Petitioner's Exhibit 22)

68. This camera was at or close to the opposite end of the hall, some distance away from the location where the incident occurred. (Petitioner's Exhibit 22) Consequently the video image is not crystal clear.

69. While it is difficult to precisely make out every detail that happened during the hallway incident by viewing the video, this finder of fact is sufficiently satisfied that the image was clear enough to make the findings of fact herein. (Petitioner's Exhibit 22)

70. As with the video in the bathroom incident, the Undersigned viewed the video on the video playback system installed in the hearing room at the Office of Administrative Hearings in Raleigh, viewing the video on the monitor on the bench as well as on the large screen monitor next to the witness box. When the hearing resumed in Goldsboro, the Undersigned viewed the

videos on the large projection screen set up in the courtroom, the same as viewing the incident in the bathroom.

71. Nothing seen in the video is inconsistent with Mr. Horn's testimony describing the incident in the hallway.

72. Respondent's witness Neil Weeks was at all relevant times the Director of Patient Advocacy at Cherry Hospital. The program he directs is an independent agency within the hospital tasked with investigating allegations of abuse, neglect and exploitation. (T.p. 195)

73. Mr. Weeks investigated the allegations that Mr. Horn pushed M.V. to the floor on the two occasions at issue, and concluded that Mr. Horn "abused" M.V. during the incident in the hallway. (T.pp. 196-199; Respondent's Exhibit 13)

74. Mr. Weeks relied upon the definition of "abuse" as: ". . . the infliction of physical or mental pain by other than accidental means or injury . . . or the depravation of services which are necessary to maintain the mental or physical health of the patient . . . ." (Respondent's Exhibit 7, p. 2, Respondent's Exhibit 13, p.2) This is the definition used by Cherry Hospital in its Clinical Care Plan, but differs from the one used by Ms. Gregory in her report.

75. Even though Mr. Weeks testified that while watching the video he could make out the details of who did what during the hallway incident, and concluded from the video that Mr. Horn "slung" M.V. to the floor, it appears to the Undersigned that Mr. Weeks was making assumptions not supported by the video. Contrary to Mr. Weeks testimony, the video is of sufficient clarity and it does not show Mr. Horn "slinging" M.V. to the floor. (T .pp. 205-211, 222, Petitioner's Exhibit 22)

76. Ms. Gregory acknowledged that no witness had described Mr. Horn "slinging" M.V. to the floor, that no witness had suggested to her that Mr. Horn had willfully or intentionally caused M.V. to go to the floor, and that from the video alone one could not conclude that Mr. Horn willfully or intentionally caused M.V. to go to the floor. (T. pp. 263-272)

77. Mr. Weeks testified that he concluded that Mr. Horn "abused" or "neglected" M.V. because his perception from watching the video was that Mr. Horn did not correctly attempt to break M.V.'s hold while trying to get away from M.V., although Mr. Horn did attempt to use CPI techniques including trying to move away from M.V., (T. pp. 207-209, 215-216)

78. Mr. Horn testified that he did try to break M.V's hold, and did try to use CPI techniques. (T. p. 58)

79. The undersigned finds Petitioner's testimony regarding the incident in the hallway to be credible, believable and consistent with what I viewed on the video.

80. Aside from being M.V.'s treating psychiatrist, Dr. Uppal regularly worked on this ward with its frequently aggressive patients, and was familiar with the CPI training. (T. pp. 171-172, 176-178)

81. Dr. Uppal also testified that the effectiveness of the CPI training in real world situations is open to question. Dr. Uppal stated that he has objected to a great deal of the CPI training as useless. He testified that under the circumstances Mr. Horn was facing, it would not be reasonable to expect "robotic" performance of specific CPI techniques, because of the normal human reactions to the stress of fending off an assault by someone as psychotic and aggressive as M.V.(T. pp. 171-178)

82. If Mr. Horn failed to perform any CPI technique exactly as prescribed, this was not for lack of trying and his efforts would have been reasonable under the circumstances. According to Dr. Uppal, in the heat of the moment everybody responds differently.

83. M.V.'s going to the floor during the hallway incident was consistent with his history of falling while assaulting others.

84. Mr. Horne did not sling M.V. to the floor in the hallway, or otherwise willfully, intentionally, or by other than accidental means cause or contribute to M.V. going to the floor in the hallway.

85. Mr. Horn's testimony as to the details of each of the two incidents in question differed in some respects from the details he gave in several interviews in Respondent's investigation. The suggestion that this makes his testimony inherently unreliable based on Dr. Uppal's testimony is without merit. Although there are some distinctions, the substance of his testimony is consistent, consistent with the video and is credible. Dr. Uppal did not examine or counsel Mr. Horn in any regard at or near the events at issue herein. Dr. Uppal was speaking in generalities and was not called upon to render a decision on the credibility of Mr. Horn.

86. To adopt the Respondent's suggestion of the inherent reliability of Mr. Horn's testimony because he had been engaged in a traumatic event and thus subject to creating "false memories" invades the province of the finder of fact to discern the truthfulness of testimony based upon the totality of the evidence. To adopt Respondent's suggestion as an absolute would be to negate the testimony of every person who either engages in or observes a traumatic even, without assessing the credibility of that witness' testimony, is not reasonable and without merit. It is for the finder of fact to weigh and determine the credibility of all evidence.

87. It is also noted that Mr. Horn's version changed on one occasion because Mr. Weeks told him that the video showed something different from what Mr. Horn was saying. Mr. Weeks refused to allow Mr. Horn to see the video. Mr. Weeks was being deceptive and untruthful with Mr. Horn, and Mr. Weeks' own testimony is not consistent with what is clearly shown in the video. No one with Respondent allowed Mr. Horn to see the video, and it was not until Petitioner's attorney obtained a copy of the video that Mr. Horn finally had a chance to see the video himself. (T.p. 209-210; Respondent's Exhibit 20, pp. 12-13) If there was an attempt to create "false memories" it was by Mr. Weeks.

88. The Undersigned does not find any of the differences in statements Mr. Horn gave during the investigation, compared to the testimony he gave at trial, to be significant or material

to the determination of the issues of whether Mr. Horn abused M.V., or whether Mr. Horn neglected M.V.

89. Without regard to whether references to the definition of "abuse" stated in the Cherry Hospital Clinical Care Plan and used by Mr. Weeks or the definition referenced by Ms. Gregory in Respondent's Exhibit 19, no "act, error or omission" of Mr. Horn constituted the abuse of M.V., a phrase common to both definitions.

90. The credible testimony given by Mr. Horn, and the previous statements given by Mr. Horn, tend to show that any "act, error, or omission" of Mr. Horn which may have caused or contributed to M.V. falling on either occasion was at most "accidental means" and therefore did not constitute abuse as defined by the patient advocate nor the definition set forth in Cherry Hospital's Clinical Care Plan. (Respondent's Exhibit 7, p.2)

91. Nothing in the video surveillance evidence shows or even suggests that any "act, error or omission" of Mr. Horn which may have caused or contributed to M.V. falling or going to the floor on either occasion constituted anything other than "accidental means".

92. There was no evidence presented at the hearing, nor even any other evidence referenced in Respondent's ICRs, suggesting that Mr. Horn willfully or intentionally inflicted any physical harm, pain, or mental anguish on M.V.

93. The Cherry Hospital Clinical Care Plan defines "neglect" as the failure to provide care or services necessary to maintain the mental and physical health of the individual served." (Respondent's Exhibit 7, p. 3)

94. One of the grounds on which Respondent substantiated the allegation that Mr. Horn neglected M.V. was that "Mr. Horn failed to utilize facility approved behavioral interventions with M.V. during the incidents". (Respondent's Exhibit 20, p.20)

95. Ms. Gregory did not describe or identify what "facility approved behavioral interventions" Mr. Horn failed to utilize. (T.pp. 235-242)

96. Ms. Gregory's ICRs include summaries of her interviews with persons other than Mr. Horn, which indicate that some of these persons had watched the same video surveillance evidence introduced at the hearing as Petitioner's Exhibit 22, and that from the review of the video these persons contended that there were actions Mr. Horn could have taken, or things he could have done differently, to avoid M.V.'s attacks, or to avoid M.V. falling, and at least intimated that some of these alternate courses of action would have been consistent with Cherry Hospital's instructions in the use of CPI techniques.

97. Those persons are identified in Ms. Gregory's reports as staff numbers 1-6, respectively. Two of those persons identified as staff members 1-6 testified at the hearing, Nurse Jackson and Mr. Weeks.

98. Mr. Horn testified extensively about his training and the use of CPI techniques and the manner in which he attempted to use those on each occasion when M.V. attacked him. (T.pp. 47-53, 109-113, 58-63, 45-53, 91-95, Petitioner's Exhibit 5)

99. Mr. Horn's testimony was that he utilized or attempted to utilize these techniques during both of his encounters with M.V.

100. Nothing in the video of either incident shows or suggests that Mr. Horn did not use or attempt to use the techniques he described in his testimony. The quality of the video in the hallway incident is not crystal clear and makes it somewhat more difficult to determine if Mr. Horn was using proper techniques or not, but the appearance is that he is making good faith efforts. There is no testimony of what he could have done differently or better.

101. The only testimony given at the hearing tending to show or suggest that Mr. Horn failed to utilize facility approved behavioral intentions in his interactions with M.V. was given by Mr. Weeks. (T.pp. 207-208, 215-218)

102. With regard to the incident in the hallway, Mr. Weeks acknowledged that where the video showed Mr. Horn backing up or trying to get away from M.V., that action was consistent with CPI training. (T.p. 207-8)

103. Mr. Weeks testified that based on his review of the video he believed that patient M.V. had grabbed hold of Mr. Horn's sleeve and that in response Mr. Horn had not correctly exercised CPI techniques in attempting to break that hold. (T.pp. 207-208, 215-218)

104. As stated above, Dr. Uppal testified that the effectiveness of the CPI training in real world situations is suspect. Dr. Uppal has objected to a great deal of the CPI training as useless. Under the circumstances Mr. Horn was facing, Dr. Uppal said that it would not be reasonable to expect "robotic" performance of specific CPI techniques, because of the normal human reactions to the stress of fending off an assault by someone as psychotic and aggressive as M.V.(T. pp. 171-178)

105. It cannot be found that Mr. Horn failed to "utilize facility approved behavior interventions" during either incident. If any such failure occurred, it did not cause or contribute to any physical harm or mental anguish to M.V.

106. Respondent also substantiated the allegation that Mr. Horn neglected M.V. on the ground that Mr. Horn failed to report M.V.'s "behaviors", or that M.V. had fallen, and "fail[ed] to ensure that M.V. received a physical assessment by the nurse, resulting in risk that physical harm [would] occur." (Respondent's Exhibit 20, p. 20)

107. On October 14, 2014, M.V. was on "precautions" because of his history of aggression and falling while being assaultive. (Petitioner's Exhibit 7) M.V. was on 1:1 observations and his 1:1 care-taker was standing in the immediate area at the time of both incidents. M.V.s 1:1 caretaker, Mr. Edmundson, failed to take any action in either incident. Mr. Edmundson did not testify in this contested case hearing.

108. Respondent's Exhibit 5 is the Cherry Hospital Clinical Care Plan Protocol for Precautions and Standard Accountability.

109. The policy defines "assigned staff" as "a staff member who is assigned the responsibility for implementing and documenting the precautions." (Respondent's Exhibit 5, p. 1)

110. The same policy describes the duties of "an assigned staff member", when assigned to a patient on "1:1 Observation". (Respondent's Exhibit 5, p. 2)

111. Where Mr. Edmundson was the "assigned staff" with the duties of 1:1 observation of M.V., Mr. Edmundson was "the staff member who was assigned the responsibility for . . . documenting the [fall] precautions." (Respondent's Exhibit 5)

112. Respondent's Exhibit 6 is the Cherry Hospital Clinical Care Plan, Falls Prevention and Management Program.

113. The policy defines a "fall" as "a sudden, ***uncontrolled***, unintentional, non-purposeful, downward displacement of the body to the floor/ground or to another object (excluding such motion as a result of recreational activities or ***as a result of violent blows or other purposeful actions inflicted upon self or others***)."(Respondent's Exhibit 6, p. 1)

114. Dr. Uppal testified that even the definition of "fall" becomes suspect in the day to day operations of the hospital and when to document something as a fall, especially as it pertains to M.V. and his "falls" during aggressive incidents. He said that a "fall" may be dependent on the perception of the viewer.

115. Dr. Uppal testified that "The issue of falling is a very gray area. Particularly in our hospital we have been working with the policies because we want to reduce falls. But how the fall is documented, how the fall is addressed or defined is still work in progress." (T.p. 167)

116. According to Dr. Uppal it is difficult to precisely define what constitutes a "fall." Because of that difficulty there is discrepancy in how and how often falls are documented in the hospital. What one person documents as a fall may not be perceived as a fall by another person who then may not document the incident. (T.p. 167)

117. According to Dr. Uppal the hospital policies encourage documenting everything, but he realizes that does not happen. (T.p. 169)

118. Mr. Horn testified during the bathroom incident that M.V. went to the floor while swinging at him, stating ". . . he missed on one of his swings, and with his weight and with his agility he actually started to slip. And what I was able to do was actually grab him and actually lower him down to the floor." According to Mr. Horn, the reason he is visible and over M.V. is because he was lowering M.V. to the floor. (T.p. 49, 92)

119. Mr. Horn consistently stated that he assisted lowering M.V. to the floor after M.V. had lost his balance and was falling to the floor. (T.p. 49, 92-93)

120. The admissible, credible and uncontroverted evidence is to the effect that M.V. *started* to fall in the bathroom, but Mr. Horn caught him and controlled his descent to the floor.

121. M.V.'s going to the floor in the bathroom was not a "fall" for which reporting was required, and if it was, Mr. Edmundson as the assigned 1:1 staff was the person having the responsibility for documenting and reporting the "fall".

122. The evidence shows that M.V. did in fact fall during the incident in the hallway.

123. Mr. Horn did not observe M.V. sustain any injury during either incident.

124. Upon assessment of M.V. by Nurse Jackson, she discerned an abrasion on his left knee and a scratch on his left hand, which did not require any medical attention; she merely "washed it with soap and water and put a Band-Aid on it." (T. pp. 23-24)

125. M.V. did not tell her how he got the abrasion or the scratch. (T. pp. 23-24) There is no evidence that Mr. Edmundson told Nurse Jackson how M.V. got the abrasion.

126. Respondent contends that even if Mr. Edmundson as the assigned 1:1 staff had the primary responsibility to report the incident and the fall, all staff who witness a fall have the obligation to report it and ensure a nurse assesses the patient, and failure of any staff to do so constitutes neglect of the patient.

127. While such a standard might be optimal, a test of reasonableness would indicate that under these conditions when the patient had a 1:1 care-taker standing there and another staff member was standing there, and then the Respondent is trying to punish Mr. Horn for NOT reporting, then such would be inane.

128. Mr. Horn testified that he did notify Nurse Jackson about the incident in the hallway (T. pp. 80-81); Nurse Jackson testified that he did not report the incident to her. (T. pp. 22-25).

129. Policy for documentation of a patient fall is addressed in the Falls Prevention and Management Program; the policy provides that "new or acute problems related to patient falls or fall precautions are documented on the falls risk reassessment form by the unit RN." (Respondent's Exhibit 6, p. 6)

130. The policy describes the interventions to be undertaken following a patient's fall. All of the required actions are described as being undertaken by the unit registered nurse, and do not address the question of when and under what circumstances health care technicians are required to report falls. (Respondent's Exhibit 6, p.5)

131. The policy does not include a provision requiring every health care worker who observes a patient fall to report or document the fall.

132. As stated above, Respondent's witness Dr. Uppal made clear his position on the definition of a "fall" as well as the documentation and reporting of such, which is contrary to the extraordinary rigidity the Respondent attempts to apply.

133. Respondent's Exhibit 19 includes summaries of Ms. Gregory's interviews with various members of Respondent's staff, identified only as staff #1 through #6.

134. Ms. Gregory indicates that some of these persons told her that "staff" were trained or taught that all staff witnessing a patient fall are supposed to report the fall to a nurse.

135. That testimony was not corroborated by any witness with knowledge. Uncorroborated statements to Ms. Gregory which are included in her report have little to no probative value. Such witnesses are not subject to examination and cross-examination to test their truthfulness and veracity.

136. None of the Cherry Hospital Clinical Care Plan Policies offered and admitted in evidence at the hearing include a requirement that every staff person who witnesses a patient fall must report or document the fall, unless the fall occurs under circumstances indicating the possibility of abuse, neglect, or exploitation. (Respondent's Exhibits 5-7)

137. Although Health Care Technician Betty Cook clearly observed the incident in the hallway, including M.V. falling, she did not report the incident or the fall. (Petitioner's Exhibit 22, T. pp. 254, 257, 268, 272)

138. Cherry Hospital did not send either a 24-hour or 5-working day report to the Registry indicating that Ms. Cook had neglected M.V. by failing to report the fall in the hallway or failing to ensure that M.V. was assessed by a nurse. (T. pp. 246-248, 254-258).

139. Ms. Gregory testified that she was made aware during the course of her investigation that Ms. Cook was present when M.V. fell in the hallway and gave a statement during the investigation describing the fall, and Ms. Gregory acknowledged that she had seen on the video that Ms. Cook was present when M.V. fell.

140. Ms. Gregory acknowledged that if she had been concerned that Ms. Cook had neglected M.V. by not reporting the fall, she would have taken action to initiate an investigation of Ms. Cook for determination of whether she had in fact have neglected M.V., but that despite her knowledge that Ms. Cook had not reported the fall, she did nothing to initiate an investigation of Ms. Cook.

141. It was not necessary to avoid physical harm or mental anguish for Mr. Horn to report either incident, where in each case Mr. Edmundson as the assigned 1:1 staff was obligated to report and document any reportable fall. Mr. Horn had no reason to doubt that Mr. Edmundson would do so. Mr. Horn did not notice M.V. sustain any injury during either incident. If M.V. actually did sustain the abrasion or the scratch during either incident – which is not proven—these

injuries were *de minimis* and it was not unreasonable for Mr. Horn to neither see nor suspect them under the facts and circumstances of this contested case.

142. Mr. Horn contends that he did report the hall incident to a nurse, but even if he did not report the incident to a nurse, he nonetheless did not neglect M.V. by failing to do so. Based on the facts and circumstances of this case, to attempt to hold Mr. Horn responsible for neglecting M.V. because he failed to report the "fall" has no merit.

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. Pursuant to 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, among other things, 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.

4. Petitioner has the burden of proving that the Health Care Personnel Registry erred in substantiating against him the allegations of abuse and neglect and, accordingly, listing his name on the Health Care Personnel Registry.

5. Cherry Hospital is a health care facility, namely a state-operated facility, as defined in G.S. 122C-3(14)f.

6. As a health care personnel, Victor Horn—namely, a Healthcare Technician—working in a state-operated facility, Horn is subject to the provisions of G.S. § 131E-256.

7. "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(1); 42 CFR § 488.301.

8. The preponderance of the admissible evidence in the record shows that Petitioner met its burden of proving that Respondent acted erroneously in substantiating the allegation that Petitioner abused M.V. during the incidents on October 14, 2013.

9. "Neglect" is defined as the failure to provide goods and services necessary to avoid physical injury, mental anguish, or mental illness. 10A N.C.A.C. 13O .0101(10); 42 CFR § 488.301.

10. The preponderance of the admissible evidence in the record shows that Petitioner met its burden of proving that Respondent acted erroneously in substantiating the allegation that Petitioner neglected M.V. during the incidents on October 14, 2013.

11. Pursuant to N.C.G.S. 150B-33(b)(11), an Administrative Law Judge may order the assessment of reasonable attorneys' fees against the State agency where the judge finds the agency has substantially prejudiced the petitioner's rights and has acted arbitrarily or capriciously. Respondent has substantially prejudiced Petitioner's rights. As a result of the decision in this case, the allegations against Petitioner Mr. Horn will be removed from the Health Care Personnel Registry. Petitioner has not met the burden of proving that Respondent acted arbitrarily and capriciously. The admissible, credible evidence in the record does not support a finding that Respondent acted in bad faith, that it failed to give fair and careful consideration to the facts, or that it failed to act with reason or the exercise of judgment. Accordingly, Petitioner is not entitled to an award of attorneys' fees in this contested case.

On the basis of the above Findings of Fact and Conclusions of Law, the Undersigned issues the following:

FINAL DECISION

The Undersigned finds and holds that there is sufficient evidence in the record to properly and lawfully support the Findings of Fact and Conclusions of Law cited above, and that the Findings of Fact properly and sufficiently support the Conclusions of Law. The Undersigned enters this Final Decision based upon the preponderance of the evidence, having given due regard to the demonstrated knowledge and expertise of the agency with respect to facts and inferences within the specialized knowledge of the agency. Based on those conclusions and the proved facts in this case, the Undersigned holds that Petitioner has carried his burden of proof and shown by a greater weight of the evidence that Respondent erred in substantiating the allegations that Petitioner abused and neglected M.V. Respondent has substantially prejudiced Petitioner's rights.

Respondent shall remove Petitioner's name from the Health Care Personnel Registry. Petitioner is entitled to the recovery of his filing fee. Petitioner is not entitled to an award of attorneys' fees in this contested case.

NOTICE

THIS IS A FINAL DECISION issued under the Authority of G.S. 150B-34. Under the provisions of Chapter 150B, Article 4, 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. G.S. 150B-46 describes the contents of the petition and requires service of petition on all parties.

In conformity with the Office of Administrative Hearing's Rules and the Rules of Civil Procedure, G.S. 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.

Under G.S. 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.

IT IS SO ORDERED.

This the 25th day of March, 2015, n*unc pro tunc January 14, 2015.*

Donald W. Overby
Administrative Law Judge