STATE OF NORTH CAROLINA

COUNTY OF WAYNE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
13 DHR 19303

CORRIE L. HUTCHINS,
Petitioner,

v.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH CARE PERSONNEL REGISTRY
Respondent.

FINAL DECISION

THIS MATTER came on for hearing before the Honorable Craig Croom, Administrative Law Judge, on January 22, 2014 in New Bern, North Carolina.

APPEARANCES

For Petitioner: Corrie L. Hutchins, appearing *pro se*
1005 Harris St., Apt. 18
Goldsboro, NC 27530

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

ISSUE

Whether Respondent substantially prejudiced Petitioner's rights and failed to act as required by law or rule when Respondent substantiated the allegation that Petitioner neglected a resident of O'Berry Neuro-Medical Treatment Center in Goldsboro, NC and entered findings of neglect by Petitioner's name in the Health Care Personnel Registry?

APPLICABLE STATUTES AND RULES

N.C. Gen. Stat. § 131E-255
N.C. Gen. Stat. § 131E-256
N.C. Gen. Stat. §150B-23
42 CFR § 488.301
10A N.C.A.C. 130.0101

EXHIBITS

Respondent's exhibits 1, 4 – 7, 9 – 16, 18, and 23 – 25 were admitted into the record.

WITNESSES

Corrie L. Hutchins (Petitioner)
Glenda Stokes (Group Home Manager)
Patricia Preston (Quality Assurance Specialist)
Sharon Richardson (Unit Director)
Bridget Rackley (HCPR Investigator)

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing and the entire record in this proceeding, the Undersigned makes the following findings of fact. In making the findings of fact, the Undersigned has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate factors for judging credibility, including but not limited to the demeanor of the witness, any interests, bias, or prejudice the witness may have, the opportunity of the witness to see, hear, know or remember the facts or occurrences about which the witness testified, whether the testimony of the witness is reasonable, and whether the testimony is consistent with all other believable evidence in the case. From the sworn testimony of witnesses, the Undersigned makes the following:

FINDINGS OF FACT

1. At all times relevant to this matter, Corrie Hutchins ("Petitioner") was a Healthcare Technician I at the O'Berry Neuro-Medical Treatment Center ("O'Berry") located in Goldsboro, North Carolina, and therefore subject to N.C. Gen. Stat. § 131E-256. (Resp. Ex. 15)

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

3. As a Healthcare Technician I, Petitioner's duties primarily concerned taking direct care of the residents of O'Berry. (Tr. p. 15)

4. Petitioner completed the Residents' Rights and Abuse/Neglect Reporting training during orientation at O'Berry. This training included learning the Administrative Policy Manual at O'Berry, which has a specific section delineated for abuse, neglect, exploitation, and other rights, infringements and/or falsification of records. This manual defines "neglect" as the "failure to provide care or services necessary to maintain the mental and physical health of the individual served." (Resp. Exs. 3 & 15)

5. At the times relevant to this proceeding, T.B. was a resident of O'Berry, sixty (60) years old, and his diagnoses included the following: mental retardation (profound); seizure disorder; ataxia; profound hearing loss; blindness; chronic constipation; hyperlipidemia; internal hemorrhoids; depression; and blind with cataract extraction of left eye. (Resp. Ex. 23)

6. On April 30, 2013, Petitioner worked the C-shift from 2:45 to 11:15 P.M. (Resp. Ex. 15)

7. Petitioner was assigned to T.B.'s care during his shift on April 30, 2013. (Resp.

Ex. 15)

8. Petitioner was familiar with resident T.B. Petitioner knew that T.B. did not like to be restrained and liked to be left alone. Each patient at O'Berry has a Person Centered Plan ("PCP"), which states the special care and treatments each specific patient requires. T.B.'s PCP stated that his balance was very unsteady and that he wore a soft-shell, protective helmet during all transfers from one chair to another, from his bed to his wheelchair and during all walking. To prevent injuries, T.B. was to also wear this helmet while sitting on the commode. Furthermore, staff should remain right there with T.B. (stand-by assistance) while he uses the bathroom to protect him from falls in the event he would try to get up without support staff. (Resp. Ex. 18; Tr. pp. 19, 38-40)

9. Petitioner was properly trained on abuse and neglect policies at O'Berry and on T.B.'s PCP in March 2013. (Resp. Ex. 1; Tr. p. 40)

10. During Petitioner's shift, he assisted T.B. in the bathroom. Petitioner was getting T.B. ready for his bath when he transferred T.B. from his wheelchair to his shower chair. T.B was not wearing his protective helmet while on the commode. Before getting in the shower, Petitioner put T.B. on the commode to have a bowel movement. While T.B. was on the commode, Petitioner prepared T.B.'s stuff for his bath. Petitioner noticed that he had forgotten T.B.'s grooming bag, which was outside of the bathing room. Petitioner left T.B. on the commode and stepped out to get his bathing bag. T.B.'s bathing bag was outside the bathroom door and in an adjacent room, about twelve (12) to fifteen (15) feet away. When Petitioner returned to the bathing room where T.B. was previously on the commode, Petitioner went to the towel bin, which is about six (6) feet away from the commode. When Petitioner returned from grabbing a towel, he noticed T.B. was lying on the floor. (Resp. Ex. 15; Tr. p. 41)

11. After Petitioner noticed T.B. had fallen on the floor, he helped T.B. up off the floor, asked T.B. if he was alright, and then proceeded to give T.B. a shower. When Petitioner started washing T.B.'s hair, he noticed there was blood. (Resp. Ex. 15)

12. After noticing blood in T.B.'s hair, Petitioner put T.B. back in his wheelchair and took him to Petitioner's supervisor, Glenda Stokes' ("Stokes"), office. Petitioner told Stokes that T.B. had fallen out of his shower chair and off the commode. T.B had hit his head against the wall. Petitioner also said he had the crossbar properly placed on T.B.'s shower chair while T.B. was on the commode. Petitioner also stated that T.B. had lifted the crossbar and fallen out of the chair while he was out of the bathroom getting T.B. a washcloth. Stokes told Petitioner that since T.B. was bleeding, they needed to fill out an incident report. Stokes called the nurse and the administrator on duty ("A.O.D"). (Tr. pp. 21-23)

13. Stokes had used the shower chair with T.B. in the past and never saw T.B. remove the crossbar to his shower chair. (Tr. p. 25)

14. Stokes completed a significant injury report after Petitioner brought T.B. to her office and reported his injuries. After the report was completed, Stokes passed it on to the

A.O.D., James Moses, and the unit director, Sharon Richardson. Furthermore, Stokes required Petitioner to write a statement of the incident. In Petitioner's handwritten statement, he stated that after he properly solidified the shower chair crossbar and rolled T.B. over the toilet, he removed T.B.'s helmet and gait belt. (Resp. Ex. 5; Tr. pp. 26-29)

15. Petitioner was required to do many things set out in the O'Berry Administrative Policy Manual. One requirement is that all staff at O'Berry be trained on each patient's PCP, which Petitioner was for T.B. T.B.'s PCP stated that he had a standby assistance policy. This policy required that the staff were required to remain with him when he was on the commode in case he tried to get up because he was capable of getting up off the commode. While difficult for T.B., T.B. is capable of opening the crossbar. Additionally, the PCP required T.B. to wear his helmet while on the commode. The purpose of this helmet was to protect T.B.'s head in case he fell. Specifically, T.B.'s PCP stated that when T.B. is in the bathroom, "T.B. uses a commode chair with a grab bar to help protect him from falls, as well as to support and help brace himself when standing up; protective paddings on the wall behind the commode to better protect from injuries resulting from falls; and he is to wear his protective helmet while on the commode. Staff should remain right there with T.B., standby assistance, while he is using the bathroom to protect him from falls, should he try to get up without support from staff." (Resp. Exs. 2 & 3; Tr. pp. 38-39, 46-47).

16. When a resident falls, O'Berry policy requires that employees are not to help the resident up until a nurse can come and assess the patient before they get up from the fall. If the client is trying to get up on their own, O'Berry employees are told that they should not fight the resident from getting up from the fall. As soon as the fall occurs, the incident should be reported to the nurse, so they can assist the resident. (Tr. p. 42).

17. Petitioner did not follow the O'Berry incident reporting policy. Instead of reporting T.B.'s fall immediately as required, Petitioner proceeded to give T.B. a shower and then discovered he was bleeding. Petitioner waited to bring T.B. to Stokes and report his injury until after T.B.'s shower and Petitioner had helped T.B. put on pajamas. (Tr. pp. 42-43).

18. On May 10, 2013, an internal investigation was initiated regarding the incident involving T.B. and Petitioner. This investigation resulted in a conclusion that substantiated a claim of neglect against Petitioner. O'Berry sent Petitioner home on disciplinary suspension with pay until the investigation was over. Prior to this hearing, Petitioner went back to work for O'Berry in a separate area not involving direct care. (Resp. Ex. 9; Tr. p. 59)

19. Petitioner spoke with Bridget Rackley ("Rackley"), the Health Care Personnel Registry ("HCPR") investigator, who investigated Petitioner's actions. At all times relevant to this matter, Rackley worked as an investigator for the HCPR. O'Berry was part of her territory. (Resp. Ex. 24; Tr. p. 67)

20. The HCPR investigates allegations of abuse, neglect, exploitation and misappropriation of resident property involving health care personnel that are employed by health care facilities. If an allegation is substantiated, the employee will be listed in the HCPR.

21. Rackley became involved in the case after receiving the twenty-four hour and five-day reports from O'Berry. She further reviewed other O'Berry documents and independently conducted an investigation. As part of her investigation Rackley made an on-site visit and conducted interviews with witnesses. Rackley did not speak with Resident T.B., as he is hard of hearing, mentally retarded, and blind. Therefore, he has not been able to recall this particular incident. (Resp. Exs. 12-15, 24; Tr. pp. 68-71)

22. Based upon the findings of the HCPR investigation, Rackley substantiated the allegation of neglect against Petitioner and notified Petitioner of her decision. (Resp. Exs. 24 & 25; Tr. pp. 83-86)

Based upon the foregoing Findings of Fact, the Undersigned Administrative Law Judge makes the following:

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter pursuant to chapters 131E and 150B of the North Carolina General Statutes.

2. All parties have been correctly designated and there is no question as to misjoinder or nonjoinder.

3. As a healthcare technician I in a neuro-medical treatment center, Petitioner is a health care personnel and is subject to the provisions of N.C. Gen. Stat. § 131E-255 and § 131E-256.

4. "Neglect" is defined as a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 10A N.C.A.C. 130.0101, 42 C.F.R. § 488.301.

5. On April 30, 2013, Corrie Hutchins, a Healthcare Technician I, neglected T.B. by leaving him in the bathroom unsupervised which resulted in physical harm – laceration to the head, removing his helmet which was supposed to remain on to prevent injuries from falls, and not following O'Berry incident reporting rules.

6. Respondent's decision to substantiate this allegation of neglect against Petitioner is supported by a preponderance of the evidence. Therefore, Respondent did not substantially prejudice Petitioner's rights, act erroneously, or act arbitrarily or capriciously by placing a substantiated finding of 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 by 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 1st day of May 2014.

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Craig Croom
Administrative Law Judge