STATE OF NORTH CAROLINA

COUNTY OF CRAVEN

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
14 DHR 05566

BERNITTA WEBSTER,
Petitioner,

v.

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

FINAL DECISION

THIS MATTER came on for hearing before the undersigned, Donald W. Overby, Administrative Law Judge, on November 19, 2014 in the Office of Administrative Hearings in New Bern, North Carolina.

APPEARANCES

For Petitioner: Bernitta Webster
Pro Se
641 Campbell Road
Vanceboro, NC 28586

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

ISSUE

Whether Respondent deprived Petitioner of property; or exceeded its authority or jurisdiction when Respondent substantiated the allegations that on or about March 23, 2014 Bernitta Webster, a Health Care Personnel, abused R.E. by willfully dragging the resident across the floor by the resident's arm resulting in physical harm and neglected R.E. by failing to provide care as she had been trained to do for a resident, resulting in physical harm.

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, 2 and 4-19 were admitted into evidence.
Petitioner's exhibits 1 and 2 were admitted into evidence.

WITNESSES

For Respondent:	Amalia Petion
	Fernika Bryant
	Shakima Wooley
	Lakin Quinn
	Betty Overman
For Petitioner:	Bernitta Webster

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing and the entire record in the 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 the matter Petitioner, Bernitta Webster, was employed as a Health Care Personnel working for the Village of Kinston ("the Village"), a health care facility in Kinston, North Carolina and therefore subject to N.C. Gen. Stat. § 131E-256. (T. pp. 13)

2. Petitioner has been a practicing Certified Nursing Assistant ("CNA") for approximately 14 years. Petitioner received training on abuse and neglect policies throughout her years as a CNA. (T. pp. 12-13)

3. Petitioner received training on resident rights as part of her employment with the Village. Petitioner completed a quiz that stated in part "Residents may refuse medication as long as it is documented, and as long as they understand the importance behind the refusal." Petitioner also testified that patients may refuse to go to bed. (T. pp. 14-16; Resp. Exh. 5)

4. Petitioner was working at the Village on May 23, 2014 from 3:00 pm to 11:00

pm, during the time of the incident with R.E. Amalia Petion ("Petion") was also working at the Village on May 23, 2014. (T. pp. 18-19; Resp. Exh. 7, 8)

6. On March 23, 2014 Petitioner worked on the 200 hall, which housed patients with Alzheimer's and dementia. Petitioner assisted R.E. with all of his activities of daily living, including mobility, dressing, toileting, and feeding. (T. pp. 16-19; Resp. Exhs. 7, 8)

7. R.E. has a care plan that instructs CNA's how to assist R.E. with his activities of daily living. Petitioner testified that CNA's are to check a resident's care plan before assisting a resident. (T. p. 17-19; Resp. Exh. 7)

8. On March 23, 2014 from 3:00 pm to 11:00 pm Petion was assigned to the 200 hall as the CNA Medtech Supervisor in Charge ("SIC"). Petion attempted to give R.E. his evening medications but he refused to take them from Petion. Petion testified that Petitioner offered to give Petitioner his medications after R.E. refused to take them from Petion. Petion handed over the medications to Petitioner. R.E. again refused to take the medications from the Petitioner, and she informed R.E. he could "either take the medicine, or go to bed." Petion went to check on another resident and when she returned witnessed Petitioner dragging R.E. down the hallway into his room. (T. pp. 30-32; Resp. Exh. 14)

9. Petion did not immediately report the incident because she feared retaliation from the Petitioner. Petion did report the incident to another CNA Fernika Bryant ("Bryant") a few days later when Petion became worried Petitioner would repeat the behavior. Bryant informed supervisor Alica Farmer ("Farmer") and administrator Laken Quinn ("Quinn") of the incident. (T. pp. 32-34; Resp. Exhs. 14, 16)

10. Farmer and Quinn performed an investigation into the incident. During the course of her investigation Quinn interviewed Petion about the incident. Quinn examined R.E. and discovered carpet burn marks on R.E.'s back and bruising on R.E.'s wrists. Quinn also looked at time logs, patient information, and interviewed all employees with any knowledge of the incident. (T. pp. 62-63; Resp. Exhs.6, 8, 9, 10, 11)

11. Shakima Wooley ("Wooley") was employed at the Village as a CNA Medtech during the time period of the incident. Wooley was friends with Petion outside of the work place. Wooley testified that Petitioner called her looking for Petion, and told Wooley she was waiting for Petion outside of her house. Wooley believed that this was an attempt to intimidate Petion. (T. pp. 52-53; Resp. Exh. 17)

12. Quinn filed a 24 hour and 5 Day Working Report with the Health Care Personnel Registry. Quinn also reported the incident to the Lenoir County Sheriff's Department and the local Department for Social Services. (T. p. 60; Resp. Exhs. 1, 2)

13. Petion, when questioned by Quinn, recounted the incident she witnessed with the Petitioner and R.E. (T. p. 33; Resp. Exh. 14)

14. Quinn interviewed Petitioner about the incident with R.E. Quinn informed Petitioner there was a witness who saw her drag R.E. down the hallway into the resident's room. (T. p. 63; Resp. Exh. 6)

15. After the facility investigation was completed, Quinn terminated Petitioner from the Village. (T. p. 65; Resp. Exh. 11)

16. 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 The Village are covered by the Registry. (T. pp. 81-83)

17. At all times relevant to the incident, Betty Overman ("Overman") 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, The Village was in her region and she received and investigated the complaint that Petitioner had abused and neglected Resident R.E. (T. p. 81-83)

18. After the complaint against Petitioner was received, it was determined it needed further investigation. As part of the investigation, Overman interviewed Petitioner, Petion, Bryant, Wooley, and Quinn. She also reviewed the resident's records and took into account the internal investigation conducted by the facility. (T. pp. 83-86; Resp. Exhs. 1, 2, 4-18)

19. On August 18, 2014, Overman interviewed Petitioner at the Lenoir County Public Library in Kinston, North Carolina. Overman learned that Petitioner was terminated as a result of this incident, and that Petitioner denied abusing R.E. Petitioner also told Overman that staff were allowed to force patients to comply with orders if they were living in the Alzheimer's unit. This is not consistent with what Petion and Quinn told Overman about the Village's policies. (T. pp. 86-87; Resp. Exh. 13)

20. On October 14, 2014, Overman interviewed Petion over the phone. Petion informed Overman that staff were trained to leave residents alone when they were combative or refusing orders. Petion also told Overman that she witnessed Petitioner dragging R.E. down the hallway on the night of March 23, 2014. (T. pp. 89-90; Resp. Exh. 14)

21. On October 15, 2014, Overman interviewed Wooley over the phone. Wooley informed Overman that Petion was afraid of Petitioner, and feared retaliation for reporting the incident with R.E. (T. pp. 53-54; Resp. Exh. 17)

22. On October 16, 2014, Overman interviewed Bryant over the phone. Bryant told Overman that residents were allowed to refuse care. Bryant also informed Overman the she reported the incident to Farmer and Quinn immediately after learning of the incident from Petion. (T. pp. 45-46; Resp. Exh. 16)

23. On, September 29, 2014 Overman interviewed Quinn by phone. Quinn informed Overman that she substantiated the allegation of abuse against Petitioner after taking into account the carpet burns on R.E., and the eyewitness account of the incident. Quinn also contacted local law enforcement and DSS regarding the incident. (T. pp. 90-92; Resp. Exh. 15)

24. Overman used a reasonable person standard to determine that dragging R.E. down the hallway caused pain, physical injury and 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. (*Allen v. NCDHHS*, 155 N.C. App. 77, 85, 88; 575 S.E.2d 565, 570, 572 (2002).

25. Overman took Petitioner's statement into consideration and viewed all the information together. Overman found the statements of Petion and Quinn to be credible and consistent. Overman found that on or about March 23, 2014 Petitioner abused R.E. by willfully dragging the resident across the floor by residents arm resulting in physical harm. She also found that, on or about March 23, 2014 Petitioner neglected R.E. by failing to provide care as she had been trained to do for a resident, resulting in physical harm. Overman wrote an investigation report which documented these conclusions. (T. pp 92-95; Resp. Exh. 18)

26. Neglect is defined as "a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." Overman determined Petitioner neglected resident R.E by failing to provide care as she had been trained to do for a resident, resulting in physical harm. (Resp. Exh. 18)

27. Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." Overman determined Petitioner abused resident R.E. of The Village by willfully dragging the resident across the floor by residents arm resulting in physical harm. (Resp. Exh. 18)

28. 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 her right to appeal. (Resp. Exh. 19)

29. Petitioner denies willfully dragging resident R.E. down the hallway to resident's room. (T. p. 21; Resp. Exhs. 11, 13)

30. Petitioner submitted two documents into evidence which pertain to her training records within the facility. One is even dated for a date after the conclusion of this hearing. It is clear even to the untrained eye that the signatures on those documents do not belong to the Petitioner, indicative of improprieties within that facility. Even so, there is no link between the forged documents and the events at issue herein, and credible evidence supports the allegations concerning Petitioner.

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. The Village 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. Documents from the Village of Kinston were forged putting the Petitioner's name on them. while the appearance is that someone may have been "out to get" the Petitioner, it is just as likely that someone was trying to cover the trial for the facility by supplying a document which may have been missing within Petitioner's personnel file. At any rate, the forgeries do not affect the decision herein.

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, 42 CFR § 488.301.

8. On or about March 23, 2014, Petitioner abused a resident R.E. by willfully dragging the resident across the floor by residents arm resulting in physical harm.

9. "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.

10. On or about March 23, 2014, Petitioner neglected a resident R.E. by failing to provide care as she had been trained to do for a resident, resulting in physical harm.

11. Respondent's decision to substantiate the 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; or exceed its authority or jurisdiction by placing substantiated findings 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

Pursuant to N.C.G.S. § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge may commence such appeal by filing 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 party seeking review must file the petition within thirty (30) days after being served with a written copy of the Administrative Law Judge's Decision and Order. Pursuant to N.C.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 thirty (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 10th day of March, 2015.

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Donald W. Overby
Administrative Law Judge