STATE OF NORTH CAROLINA

COUNTY OF MOORE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
14DHR05763

Mary Jones Petitioner v. Department of Health and Human Services, Division of Health Service Regulation Respondent	**FINAL DECISION**

THIS MATTER came on for hearing before Hon. J. Randolph Ward, Administrative Law Judge, on September 25, 2014 in Asheboro, North Carolina. Following receipt of the parties' proposed findings and conclusions, the following Final Decision was prepared.

APPEARANCES

For Petitioner: Ellis B. Drew III
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For Respondent: Candace A. Hoffman
Assistant Attorney General
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ISSUE

Whether Respondent erred in finding that the facts substantiated the allegations and justified the "Entry of Finding" on the Health Care Personnel Registry that, "On or about March 3, 2014, Mary E. Jones, a Nurse's Aide, neglected a resident, D.H., by failing to properly utilize the Hoyer lift, dropping the resident, picking the resident up without having a nurse assess for injuries and lying about the incident to avoid blame resulting in a delay of treatment."

APPLICABLE STATUTES AND RULES

N.C. Gen. Stat. §§ 150B-23, 131E-255(c), 131E-256, 10A N.C.A.C. 13O .0101(10), and 42 CFR § 488.301

EXHIBITS

Respondent's exhibits ("R. Exs.") 1-6, 7A & B, 8A & B, 10A & B, and 11-13 were admitted into the record.

WITNESSES

For Petitioner: Mary E. Jones, CNA (Petitioner)

For Respondent: Ramona Derrickson, CNA
Jena Darsey, LPN
Tracy Bain, RN
Athena Foreman, RN

UPON DUE CONSIDERATION of the submissions and arguments of counsel, the documents and other exhibits admitted, and the sworn testimony of each of the witnesses, considering their opportunity to see, hear, know, and recall the relevant facts and occurrences about which they testified; any interests they may have; and whether their testimony is reasonable and consistent with other credible evidence; and, assessing the greater weight of the evidence from the record as a whole, in light of applicable law, now therefore, based upon the preponderance of the credible evidence, the undersigned Administrative Law Judge makes the following:

FINDINGS OF FACT

1. At all times relevant to this matter, Petitioner Mary E. Jones was employed as a Certified Nursing Assistant at Pine Lake, a nursing home in Carthage, North Carolina, and therefore, was subject to N.C. Gen. Stat. § 131E-256. (T. p. 10) She had been employed at Pine Lake since 1996.

2. Petitioner completed all required training related to her job responsibilities. She received instruction on how to report an accident or incident involving a resident, and how to assist other CNAs. She also received training with regard to Pine Lake's policies on investigating incidents of abuse and neglect of residents. (T. pp. 23-26; R. Ex. 3)

3. Petitioner acknowledged receiving Pine Lake's Elder Abuse Training, indicating her knowledge of and agreement to comply with their code of conduct, and further indicating her understanding that failure to provide services necessary to avoid physical harm or mental anguish is considered caretaker neglect. Additionally, Petitioner acknowledged that she understood that it was Pine Lake's policy to report any falls to a nurse supervisor before attempting to move the resident. Petitioner acknowledged that she should promptly report any incident or accident that occurred with a resident. (T. pp. 23-26, 28; R. Ex. 3)

4. Petitioner received in-service training on how to properly handle falls, restraints, lifts,

and reporting. (T. p. 23; R. Ex. 3)

5. On March 3, 2014, Petitioner was with D.H., a resident at Pine Lake, when D.H. fell to the floor from a Hoyer lift, sustaining a small gash on the left side of his head which required stitches and an internal brain bleed. (T. pp. 26-30; R. Ex. 5)

6. Resident D.H. was 64 years old at the time of the incident. He suffered from Clostridium difficile colitis, Hyponatremia, chronic respiratory failure, Hypertension, and chronic anemia. D.H. was bed-bound, in a vegetative state, and required total care. (T. p. 15, R. Exs. 5 & 8A) The use of a Hoyer lift was required to leave his bed. His plan of care included that his weight should be documented once a month, using the Hoyer lift. (T. p. 16)

7. On March 3, 2014, Petitioner asked Ramona Derrickson to assist her with weighing D.H. with the Hoyer lift. (T. p. 16; R. Exs. 6 & 11) Petitioner testified that while weighing D.H., he fell out of the Hoyer lift and hit his head on the floor. Petitioner and Ms. Derrickson picked up D.H. and put him back into his bed before proper evaluation of his injuries, contrary to their training. They also failed to immediately report the incident to a nurse or supervisor, as they had been trained to do, causing a delay in treatment of the resident's injuries. (T. pp. 26-30, 33; R. Exs. 6 & 11)

8. By happenstance, Jena Darsey, LPN, came to D.H.'s room to store some supplies at some point after Petitioner and Ms. Derrickson put D.H. back into the bed. Ms. Darsey noticed blood on the floor and on the bed. Ms. Darsey examined D.H. and found a wound on the back of his head. Ms. Darsey asked Petitioner and Ms. Derrickson what happened to D.H. Petitioner testified that she told Ms. Darsey that D.H. jerked his head back while Petitioner was weighing him and bumped his head on the side rail of the bed. Ms. Darsey then contacted the wound nurse and the Director of Nursing, Tracy Bain. (T. p. 64; R. Exs. 4, 8A, & 8B)

9. After stopping the bleeding, Ms. Darsey and Ms. Bain decided to send D.H. to the hospital ER for stitches. Ms. Darsey recorded in D.H.'s progress notes what she was told by Petitioner about the incident and what she observed firsthand about D.H.'s injuries. (T. p. 67; R. Exs. 4, 8A, & 8B)

10. Ms. Bain performed a "facility investigation" into the incident. She brought Petitioner and Ms. Derrickson to her office separately to ask them about the cause of the accident. Both initially told Ms. Bain that D.H. hit his head on the side rail of his bed. (T. pp. 71-78; R. Exs. 10A & 10B)

11. Later in the evening of March 3, 2014, Ms. Derrickson went to Ms. Bain and admitted that D.H. had fallen from the Hoyer lift and hit his head on the floor. Ms. Bain immediately called the hospital and informed the doctor the actual circumstances that led to D.H's injury. Ms. Bain told Ms. Darsey to send both Petitioner and Ms. Derrickson home and to take the Hoyer lift out of service. (T. pp. 75-76; R. Exs. 8A, 8B, 10A, & 10B) CT scans at the hospital revealed that D.H. suffered a brain hemorrhage in the left

frontal lobe as a result of the fall from the Hoyer lift. (T. p. 83; R. Ex. 5)

12. Ms. Bain interviewed Petitioner again on March 4, 2014. Initially, Petitioner continued to lie about the incident and told Ms. Bain that D.H. had bumped his head on the side rail of the bed. Ms. Bain informed Petitioner that Ms. Derrickson told the truth about the incident with D.H., and shortly thereafter, Petitioner admitted to Ms. Bain that D.H. had fallen and hit his head on the floor. (T. p. 76; R. Exs. 10A & 10B) On March 4, 2014, Ms. Bain filled out the 24-Hour Initial Report detailing the incident resulting in D.H.'s injury. (T. p. 71; R. Ex. 1)

13. As part of her investigation, Ms. Bain had the Hoyer lift inspected. The inspector found that the lift was functioning properly. (T. p. 73; R. Exs. 10A & 10B) On March 5, 2014, Ms. Bain completed and filed a 5-Working Day Report, classifying the incident as "resident neglect" resulting in a fall and injury, and that the employees "placed resident in bed [and] then lied to charge nurse and Director of Nursing about what happened." (T. p. 72; R. Ex. 2) Both Petitioner and Ms. Derrickson were terminated by Pine Lake. (T. p. 30; R. Exs. 10A & 13)

14. On or about March 3, 2014, Petitioner Mary E. Jones, a Certified Nursing Assistant, neglected a resident ("D.H.") by: failing to properly use the Hoyer lift, resulting in the resident's fall to the floor; picking the resident up and putting him back into bed before having a nurse assess his injuries; failing to promptly report the fall, thus resulting in a delay of proper evaluation; and lying about how the injury occurred, putting the resident at risk of being inappropriately treated for his injury. (T. pp. 13, 17-20, 26-30; R. Exs. 6 & 11)

15. The Health Care Personnel Registry Section's Investigation 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 licensed facilities in North Carolina that provide patient care, including personnel at Pine Lake. (T. p. 36)

16. At all times relevant to this incident, Athena Foreman was employed as an investigator for the HCPRIB. She is charged with investigating allegations against health care personnel in the north central region of North Carolina. Accordingly, Pine Lake was in her region, and she received and investigated the complaint that Petitioner had neglected Resident D.H. (T. pp. 35-36)

17. After the complaint against Petitioner was received, it was determined that further investigation was needed. As part of the investigation, Ms. Foreman interviewed Petitioner, Ms. Darsey, Ms. Derrickson, and Ms. Bain. She also reviewed the resident's records and took into account the internal investigation conducted by the facility. (T. pp. 35-37; R. Exs. 1-7B, 10A, & 10B)

18. On June 9, 2014, Ms. Foreman interviewed Petitioner at the Southern Pines Library. Ms. Foreman asked Petitioner to clarify why she did not report the incident with D.H. to a

nurse. Petitioner told Ms. Foreman that she got scared when she dropped D.H. and lied to the nurse about what happened. Petitioner also admitted to Ms. Foreman that she knew she violated Pine Lake's policy on incident/accident reporting. (R. Ex. 6)

19. On May 20, 2014, Ms. Foreman interviewed Ms. Bain at Pine Lake. Ms. Bain explained that Petitioner had been terminated in part because D.H. had been allowed to fall, but primarily because she had moved him after the fall, disregarding the danger of exacerbating his injuries. Ms. Bain also believed that because Petitioner lied about what had occurred, D.H. did not immediately receive the proper treatment. (T. pp. 77-78, 81; R. Ex. 10A) Ms. Foreman also interviewed Ms. Darsey, who told Ms. Foreman that Ms. Derrickson came to her upset on the afternoon of March 3, 2014, and admitted D.H. had fallen from the Hoyer lift. (R. Ex. 8A)

20. On May 29, 2014, Ms. Foreman interviewed Ms. Derrickson at Southern Pines Library. Ms. Derrickson informed Ms. Foreman that she initially lied about what happened to D.H., but she eventually told another CNA and Ms. Darsey the truth about D.H.'s fall from the Hoyer lift. (T. p. 57; R. Ex. 7A)

21. Ms. Foreman concluded that Petitioner neglected Resident D.H. and wrote an investigation report which documented her conclusions. (T. pp. 10-79; R. Exs. 4, 6, 7A-8B, & 10A-11)

22. Petitioner was properly notified by letter that HCPRIB's finding of neglect would be listed against her name in the Health Care Personnel Registry and of her right to appeal. (R. Ex. 12) Petitioner timely sought this hearing.

23. To the extent that portions of the following Conclusions of Law include findings of fact, such are incorporated by reference into these Findings of Fact.

Upon the foregoing Findings of Fact, the undersigned makes the following:

CONCLUSIONS OF LAW

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

2. The Health Care Personnel Registry Section of the North Carolina Department of Health and Human Services, Division of Health Service Regulation, 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 neglected a resident in a health care facility.

3. Pine Lake of Carthage is a health care facility as defined in N.C. Gen. Stat. § 131E-255(c) and N.C. Gen. Stat. § 131E-256(b). As a Certified Nursing Assistant working in a

health care facility, Petitioner is subject to the provisions of N.C. Gen. Stat. § 131E-256.

4. For the purposes of the Health Care Registry, "neglect" is defined as a failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness. 10A N.C.A.C. 13O .0101(10), 42 CFR § 488.301.

5. Petitioner had the burden of proving that Respondent substantially prejudiced her rights, failed to act as required by law or rule, exceeded its authority, or failed to use proper procedure when it substantiated the allegations that Petitioner neglected D.H. on March 3, 2014, and entered said findings against Petitioner on the North Carolina Health Care Personnel Registry. *Overcash v. N.C. Dept. of Env't & Natural Res.*, 179 N.C. App. 697, 699, 635 S.E.2d 442, 444-45 (2006)*; Byrd v. N.C. Dept. of Health and Human Services*, 2013 WL 8116135, 13DHR12691 (NC OAH, 5 Nov. 2013). Petitioner failed to sustain the burden of proof.

6. On or about March 3, 2014, Petitioner neglected Resident D.H. by failing to properly use the Hoyer lift, resulting in the resident's fall; moving the resident before obtaining a medical clearance that he could be moved without exacerbating his injuries; failing to promptly report the accident; and misrepresenting the nature of the accident in a way that could affect the resident's treatment.

7. To the extent that portions of the foregoing Findings of Fact include conclusions of law, such are incorporated by reference into these Conclusions of Law.

Based on the foregoing Findings of Fact and Conclusions of Law, the undersigned makes the following:

FINAL DECISION

The undersigned hereby determines that Respondent's decision to enter a finding that Petitioner neglected a nursing home resident on the Health Care Personnel Registry was justified and appropriate and 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 19th day of December, 2014.

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J. Randolph Ward
Administrative Law Judge