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OFFICE OF ADMINISTRATIVE HEARINGS
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STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
22 DHR 00028

Kenyatta Renee Andrews Petitioner, v. Department of Health and Human Services, Division of Health Service Regulation Respondent.	AMENDED FINAL DECISION

On June 6, 2022, Administrative Law Judge Melissa Owens Lassiter conducted an administrative hearing in this contested case at the Office of Administrative Hearings in Raleigh, North Carolina. This case was heard pursuant to N.C. Gen. Stat. §§ 150B-23 and 131E-256 and Petitioner's appeal, filed on January 4, 2022, of Respondent's substantiation of an allegation that Petitioner neglected resident SH at Peace Cottage, a psychiatric residential treatment facility, on August 3, 2021.

APPEARANCES

For Petitioner: Kenyatta Andrews, *Pro Se*
Nolanville, Texas

For Respondent: William F. Maddrey
Assistant Attorney General
N.C. Department of Justice
Raleigh, North Carolina

APPLICABLE STATUTES AND RULES

N.C.G.S. § 131E-256 and N.C.G.S. § 150B-1, *et seq.*
10A N.C.A.C. 13O .0101(10)
42 C.F.R. § 488.301

ISSUE

Whether Respondent correctly substantiated and entered on the Health Care Personnel Registry an allegation that Petitioner neglected a resident of Peace Cottage, a psychiatric residential treatment facility, on August 3, 2021, by failing by failing to follow training on de-escalation techniques resulting in injury to the resident?

EXHIBITS ADMITTED INTO EVIDENCE

For Petitioner: None

For Respondent: A, B, D, E, F, H, I

WITNESSES

For Petitioner: Petitioner, Michelle Crite

For Respondent: DeMonica McIver Saylor, Kathy Moshman

FINDINGS OF FACT

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing and the entire record in this proceeding, including documents admitted into evidence, having weighed all the admissible evidence and has assessed the credibility of the witnesses by considering the appropriate factors for judging credibility, including, but not limited to, the demeanor of the witness, any interests, bias, or prejudice the witnesses may have, the opportunity of the witnesses to see, hear, know or remember the facts or occurrences about which the witnesses testified, whether the testimony of the witnesses is reasonable, and whether the testimony is consistent with all other believable evidence in this contested case, the Undersigned finds as follows:

Parties

1. Thompson Child and Family Focus ("Thompson") is a psychiatric residential treatment facility in Mecklenburg County, North Carolina which provides clinical and behavioral treatment, and developmental education to children in four cottages including Peace Cottage in Matthews, North Carolina.

2. Petitioner has been as a residential care specialist and a health care personnel at Thompson's Peace Cottage since March or April 2018. The purpose of Petitioner's position was to provide direct care to children in the resident treatment program by "providing a safe therapeutic home setting in a positive, consistent and structured environment." (Resp Ex E, p 2)

Procedural Background

3. On or about August 9, 2018, DeMonica McIver, Quality Improvement Specialist with Thompson, submitted an Incident Response Report to Respondent Health Care Personnel Registry ("HCPR") that resident SH had reported "I have nail prints because Ms. Kenyatta and Ms. Stephanie dug their nails in my arms." (Resp Ex B) In that Report, Ms. McIver described the cause of the incident was:

> Based on the investigation, the client [SH] was not ready to leave the cafeteria because she wasn't finished with her lunch. The staff stated that they provided her with extra time, but she still wasn't finished.

(Resp Ex B) The Report also indicated that a nurse's assessment noted a red mark under SH's right armpit, to the right of her breast. In addition, the Staff at Thompson provided coaching and re-training on TCI de-escalation techniques and utilization of trauma informed practices (CARE model). (Resp Ex B)

4. Ms. McIver reviewed video footage of the alleged incident from August 3, 2021, interviewed Petitioner, and another residential care specialist, Stephanie Mayers, who was present during the alleged incident involving resident SH.

5. By letter dated September 2, 2021, Respondent HCPR notified Petitioner that it was investigating an allegation that she abused a resident of Peace College on or about August 3, 2021 and such allegation would be listed on the HCPR.

6. From September 2, 2021 through November 30, 2021, HCPR Nurse Consultant/Investigator Joi B. Deberry investigated the abuse allegation against Petitioner, including an on-site investigation at Peace Cottage on November 18, 2021. Ms. Deberry interviewed resident SH, Petitioner, Stephanie Mayers, and reviewed Petitioner's personnel file, SH's medical records, the facility's investigative documentation, the facility's video footage of the incident, and a photograph of SH's arm. The photo of SH's arm was undated. (Resp Ex E, p 9)

7. On November 30, 2021, Ms. Deberry notified Petitioner by letter that Respondent was substantiating the allegation that Petitioner "neglected a resident of Peace Cottage in Matthews" and would enter a finding on the HCPR as follows:

> On or about 8/3/2021, Kenyatta Andrews a Health Care Personnel, neglected a resident (SH) by failing to follow training on de-escalation techniques resulting in injury to the resident.

(Resp Exs E and F)

8. Respondent did not substantiate the allegation of abuse against Petitioner. (Resp Ex E, p. 1)

9. On January 4, 2022, Petitioner appealed Respondent's decision to substantiate the neglect allegation against her. Petitioner contended that Respondent did not conduct a complete investigation as Respondent did not contact Petitioner's witnesses for a statement. (Petition, Prehearing Statement)

Adjudicated Facts

10. At the contested case hearing, Ms. McIver (now Saylor), with Thompson, explained how resident SH alleged, on August 4, 2021, that Petitioner and Ms. Mayers dug their fingernails into her arm and complained of discomfort. A nurse assessed SH and found red marks under SH's right armpit. (Resp Ex D)

11. Ms. McIver also reviewed the facility's video footage of August 3, 2021 (Resp Ex H) and described how the footage showed Petitioner lift SH up and carried (carry) SH to the van. Ms. McIver opined that Petitioner's actions were not in line with the correct method in that Petitioner was expected to stay with the youth and get her to work herself out. Petitioner was not supposed to move the resident. Ms. McIver interviewed Petitioner about the allegation. Petitioner admitted that she picked up SH on August 3, 2021 and carried her to the van. However, Petitioner claimed she did not scratch SH because Petitioner did not have nails and was also unaware of any markings on SH's arm. Ms. McIver also interviewed Stephanie Mayers. According to Ms. McIver's testimony, Mayers confirmed that Petitioner moved resident SH to the van. (McIver testimony)

12. The facility did not substantiate abuse against Petitioner and did not terminate Petitioner's employment after its investigation concluded. On September 2, 2021, the facility terminated Petitioner's employment.

13. HCPR Nurse Consultant/Investigator Joi B. Deberry investigated the abuse allegation against Petitioner, including an on-site investigation at Peace Cottage on November 18, 2021. However, Ms. Deberry did not testify at the contested case hearing either in person or remotely. There was no evidence presented at hearing why Ms. Deberry was unavailable to testify.

14. Ms. Kathy Moshman, a Nurse Consultant II supervisor, testified on behalf of HCPR regarding Respondent's investigation into the allegation against Petitioner. Ms. Moshman identified Ms. Deberry's investigative report (Resp EX E) and testified regarding the specifics of Respondent's investigation into the allegations against Petitioner.

15. Ms. Moshman agreed with Ms. Deberry's September 2, 2021 letter to "screen in" or investigate the abuse allegation against Petitioner. She noted at hearing that the facility's video footage showed only Petitioner, not Stephanie Mayers, picking up and carrying resident SH outside the cafeteria in a non-approved TCI (Therapeutic Crisis Intervention) technique on August 3, 2021 and this technique led to resident SH being scratched. The investigative report concluded that Petitioner "did not intentionally abuse or harm SH." (Resp Ex, p 1) Based on that finding, Respondent did not substantiate the abuse allegation against Petitioner

16. However, Ms. Deberry decided to investigate Petitioner for an allegation of neglect of SH on August 3, 2021. There was neither a letter documenting Respondent's

notification of an entry of an allegation of neglect against Petitioner on the HCPR nor a letter unsubstantiating the abuse allegation against Petitioner introduced at hearing.

17. During her employment with Thompson, Petitioner was trained in Therapeutic Crisis Intervention (TCI), Physical Restraint, Skills, the Client Rights Policy, Policy 4.01, the Policy for Reporting Suspected Abuse or Neglect, Policy 4.02, and Resident's Rights. (Resp Exhs E, I) According to the TCI Training Curriculum cited in the Investigative Report, staff at Thompson, including Petitioner, were trained on the following:

> The Protective Stance. In general, when staff approach an upset young person who is potentially violent, it is important for the adult to approach the young person from the side, with the adult's hands held out in front of the body in an open and protective manner, respecting the young person's personal space and positioning the adult in a balanced protective stance. The adult can follow the young person's movements, staying off-side and at a safe distance (at least 5-6 feet/1.5-2 meters). It is important to avoid cornering or boxing in the young person. . . .1. Assume a protective stance: The adult places his feet shoulder distance apart in a balanced stance and puts his hands up in front of his body with the palms facing out (Figure 1). The adult should stand at least 5-6 feet/1.5-2 meters away at an angle from the child, communicating a non-threatening message (Figure 1).
>
> . . . Small Child Restraint Without the Use of a Wall: "1. Obtain a hold: From behind the child, the staff initiating the restraint assumes a balanced stance and then pushes forward on the back of the child's upper arms which automatically crosses the child's arms in front of her *(Figures 69, 70)*. The second staff remains in a position to monitor the restraint if not needed to secure the legs. 2. Secure the arms: The adult, who is behind the child, grasps the child's crossed arms
> above the wrist, *(Figure 71)* and secures the arms by locking the elbows *(Figure 72).* This is done by placing the child's top arm under the other arm, resulting in the child's wrist under the elbow. The adult should have her hand on the child's opposite arm (i.e., the adult's right arm on the child's left arm). At this point the adult must assess whether the child is continuing the violence. If the answer is no, the adult should end the restraint. 3. Move to the floor: If the child has not calmed enough to be released from the restraint, then the adult brings the child to the floor by stepping backward and bringing the child down along the inside of her leg *(Figure 73*). The adult restraining the child should not bend over, but should bend down from the knees, in order to maintain her spine in an erect position. The adult breaks the child's fall with her knee while keeping the child close *(Figure 74).* With the adult on her knees behind the seated child, the child can be effectively held. This should be done gently, with caution not to yank or pull the child down. . . . 4. Securing the legs: If another adult is needed to help control the child's legs, this person enters from the side, wrapping his arms

around the child's legs, avoiding knees and ankles, facing away from the child *(Figures 76,77, 78)*

18. In addition, Respondent's Exhibit A, Thompson's TCI Protocol, issued under Thompson's letterhead and signed by Petitioner on March 18, 2018, stated that the following reporting procedure is to be followed "when other staff are not following Agency Policy and Procedures and/or TCI Curriculum regarding a client in crisis that could result in potential injury or harm:"

1) Request that the staff member follow proper protocol …

2) Remind the staff member that TCFF has a 'no escorting' policy per training curriculum which specifically means no grabbing/pulling by the extremities, carrying, lifting, pushing, etc.

3) Ask the staff member to disengage from the situation and let someone else take over the situation.

(Resp Ex A)

19. The medical information Ms. Deberry reviewed at the facility and cited in her investigative report and the facility's Incident Report showed the following: On August 3, 2021, SH was a nine-year-old female who had been admitted to Thompson's Peace Cottage on or about April 19, 2021. Her diagnoses were Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, and Attention Deficit Hyperactivity Disorder, Combine Type. SH was 49 inches tall and weighed approximately 64 pounds. SH's Person-Center Plan noted that "SH struggled with displaying verbal and physical aggression towards peers and staff." As of August 3, 2021, "SH continues so [sic] display defiance and refuses to follow rule and expectations given by resident care support staff. When SH is upset, she will yell, use profanity, hit kick, and slam doors."

20. Respondent's investigation noted that Petitioner and Stephanie Mayers described SH as being physically aggressive on August 3, 2021 and attempted to elope from the cafeteria. SH had a reputation as being an "eloper" or someone who likes to run away from the facility.

21. The facility's investigation documents indicated that when the nurse examined SH on August 4, 2021, the nurse noted a red mark under SH's right armpit, to the right of her breast. "No swelling or bruising was noted." When the nurse asked SH what happened, SH "shrugged her shoulders." (Resp Ex. E. p 4)

22. According to Ms. Deberry's notes, Petitioner denied digging her nails into SH's arms but admitted carrying SH to the van and admitted that such method was not an approved TCI technique. Petitioner acknowledged when she reached the van with SH, Petitioner's supervisor told Petitioner that her carrying SH was not an approved TCI technique. Ms. Deberry's notes also indicate that Petitioner acknowledged that she

should have let go of SH after her coworker let go of SH. (Resp Ex E, pp 4-5)

23. Ms. Moshman agreed with Ms. Deberry's substantiated finding that Petitioner neglected resident SH by failing to follow training on de-escalation techniques which caused harm to resident SH. Ms. Moshman opined that Petitioner was trained on the proper techniques to use but failed to follow such training.

24. During Petitioner's interview with Ms. Deberry, and during her contested case testimony, Petitioner explained that they were in the cafeteria eating lunch, when SH got upset with another staff. As Petitioner, Ms. Mayers and SH were leaving the cafeteria, SH refused to get on the van to return to the cottage and flopped to the ground. Petitioner and Ms. Mayers waited for SH to get up on her own. SH said she was ready to stand up, but she flopped down again. Petitioner "scoops" up SH, picks SH up by the arms, from behind SH, and carries SH to the van.

25. Respondent's investigative report by Ms. Deberry was admitted into evidence at the contested case hearing. Inclusion of resident SH's medical documentation, Petitioner's personnel file and training were admissible as business records. However, the investigative report contained a substantial amount of inadmissible and uncorroborated hearsay; those statements included Ms. Mayers' statements to the facility and to Ms. Deberry, resident SH's statements to the facility and Ms. Deberry, and the nurse's assessment of SH after the August 3, 2021 incident. While Respondent may have considered such information in the process of reaching its decision, the Tribunal will not do so. "The North Carolina Rules of Evidence as found in Chapter 8C of the General Statutes shall govern in all contested case proceedings, except as provided otherwise in these Rules and G.S. 150B-29; 26 N.C.A.C. 3.0122. There was no evidence presented at hearing as to the reliability of such hearsay statements and under what hearsay exceptions under the N.C. Rules of Evidence such hearsay should be admitted into evidence to prove the truth of the matter, i.e., that Petitioner neglected resident SH on August 3, 2021.

26. Ms. Deberry's report indicated the photo of the alleged injury to SH showed two small, reddened areas. However, Ms. Deberry noted that "the photo was not dated to indicated when the photo was taken." (Resp Ex E) Because such photo was undated and no witness testified at hearing authenticating when the photo was taken and who took the photo, such photo was not sufficiently reliable to show SH's injury sustained on August 3, 2021 by Petitioner's actions, and therefore, will not be considered as admissible evidence for substantive purposes.

27. In addition, resident SH did not appear at the contested case hearing and did not testify either in person or remotely at the contested case hearing. There was no evidence presented at hearing that SH was "unavailable" to testify or that SH's statements to the facility or to Ms. Deberry qualified as a hearsay exception to allow SH's statements to be considered as evidence at this contested case hearing. Therefore, SH's statements are inadmissible hearsay and will not be considered as substantive evidence.

28. After excluding the above-cited hearsay statements and undated photo, the only remaining competent evidence presented at hearing regarding the August 3, 2021 incident was Petitioner's testimony and the facility's video footage. Such evidence established that after resident SH flopped to the floor, Petitioner waited a short amount of time, Ms. Mayers walked away, and Petitioner picked up resident SH from behind and underneath SH's arms and carried SH outside the facility.

29. The evidence at hearing also established that Petitioner was trained on TCI protocol.

a. Thompson's TCI protocol in Respondent's Exhibit A described the reporting protocol when a staff member is not following the TCI protocol. Such procedure stated that TCFF has a "no escorting policy" per training curriculum, specifically "no grabbing/pulling by the extremities, carrying, lifting, pushing, etc."

b. In contrast, the TCI Procedure listed in Ms. Deberry's report permitted staff to perform a hold on a small child from behind by pushing "forward on the back of the child's upper arms which automatically crosses the child's arms in front of her." The staff releases the child if she/he is no longer violent, but policy instructs staff to move the child to floor if the child remains violent. (Resp Ex E, p. 2)

c. Comparing the two policies, one appears to prohibit carrying/pulling/pushing, but the other allows staff to perform a hold on a child.

30. Based on the facility's video footage of the August 3, 2021 incident and Petitioner's statement, it appears Petitioner performed a hold on resident SH, which TCI Curriculum allowed, although not completely perfect and in perfect conformity with the TCI Curriculum. According to Respondent's investigative report, Petitioner admitted to Ms. Deberry that her method of carrying SH was not an approved TCI technique, she should have let SH go as Ms. Mayers did, and she did not intend to harm resident SH.

31. Petitioner explained that she had no prior disciplinary actions, and there was no evidence of any prior allegations of abuse or neglect against Petitioner before August 3, 2021.

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction over the parties and subject matter of this contested case. N.C.G.S. § 131E and Article 3 of N.C.G.S. § 150B.

2. All parties have been correctly designated and there is no question of misjoinder or nonjoinder. Notice of Hearing was provided to all parties in accordance with N.C.G.S. § 150B-23(b).

3. By statute, the burden of proof in this contested case is on Petitioner. N.C.G.S. § 150B-25.1.

4. To the extent that the Findings of Fact contain Conclusions of Law, and vice versa, they should be so considered without regard to their given labels. *Charlotte v. Heath*, 226 N.C. 750, 755, 440 S.E.2d 600, 604 (1946). A court or other hearing authority need not make findings as to every fact that arises from the evidence and need only find those facts which are material to the settlement of the dispute. *Flanders v. Gabriel,* 110 N.C. App. 438, 440, 429 S.E.2d 611, 612, *aff'd,* 335 N.C. 234, 436 S.E.2d 588 (1993).

5. N.C.G.S. § 131E-256(a)(1) requires Respondent to maintain a registry ("health care personnel registry" or "HCPR") containing the names of all unlicensed health care personnel working in health care facilities in North Carolina who have substantiated findings that they abused, neglected, or exploited a resident in those facilities. By Federal law, Respondent is mandated to establish and maintain a registry containing the names of health care personnel working in health care facilities in North Carolina who have been subject to a substantiated finding of neglect, abuse, misappropriation, diversion of drugs, or fraud. N.C.G.S. § 131E-256(a)(1).

6. Peace Cottage, as part of Thompson Child and Family Focus, is a "health care facility" for purposes of the HCPR. N.C.G.S. § 131E-256; N.C.G.S. § 122C-3(f).

7. As health care personnel working in a health care facility, Petitioner is subject to N.C.G.S. § 131E-256.

8. "Neglect" is "the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." 42 C.F.R. § 488.301; 10 N.C.A.C. 13O.0101. This definition requires evidence that the services that were not provided by the accused health care personnel were necessary "to avoid physical harm" and the other consequences referenced in the rule.

9. Thompson's determination as to Petitioner's actions towards resident SH, while relevant, is not determinative in this contested case.

10. The preponderance of the evidence presented at hearing showed Petitioner picked up resident SH from behind and underneath SH's arms, then carried SH to the van outside the cafeteria on August 3, 2021. The TCI protocol permitted staff to perform a hold on a small child from behind by crossing the child's arms, while the protocol listed in Respondent's Exhibit A prohibited any carrying/pulling/pushing/escorting.

11. The only evidence of potential harm to SH was SH's hearsay statements made to Thompson staff and Ms. Deberry and an undated photo, allegedly of SH's arms. However, no evidence was presented at hearing justifying the admission of SH's hearsay statements as any hearsay exception under the N.C. Rules of Evidence. No witness authenticated when or by whom the undated photo was taken, and the photos was of

resident SH after the August 3, 2021 incident. The only competent evidence about the red marks on SH's arm was Petitioner's denial of digging her nails into SH's armpit. Therefore, there was insufficient evidence to prove by a preponderance of the evidence that resident SH suffered physical harm, pain, mental anguish, or emotional distress on August 3, 2022.

12. The preponderance of the evidence in this contested case simply does not support Respondent's conclusion that Petitioner failed to provide goods and services necessary to prevent physical harm, pain, and/or mental anguish to SH on August 3, 2021.

13. Petitioner met her burden of proof that Respondent substantially prejudiced her rights and failed to use proper procedure in substantiating the allegation that Petitioner neglected SH on August 3, 2021 and entering that finding against Petitioner on the North Carolina Health Care Registry.

14. Based on the foregoing, Respondent should remove Petitioner's name from the Health Care Personnel Registry.

FINAL DECISION

Based on the Findings of Fact and Conclusions of Law, the undersigned hereby **REVERSES** Respondent's action. Respondent shall remove Petitioner's name from the North Carolina Health Care Personnel Registry and the records of the North Carolina Health Care Personnel Registry shall reflect that the finding of neglect was not established.

NOTICE OF APPEAL

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 as indicated by 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.

IT IS SO ORDERED.

This the 23rd day of August, 2022.

Melissa Owens Lassiter
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center who subsequently will place the foregoing document into an official depository of the United States Postal Service.

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Petitioner

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This the 23rd day of August, 2022.

Daniel Chunko
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