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STATE OF NORTH CAROLINA

COUNTY OF HARNETT

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
22 DHR 00587

Shirley Jean Spears, Petitioner, v. Department of Health and Human Services, Division of Health Service Regulation, Respondent.	**FINAL DECISION**

THIS MATTER came on for hearing before Administrative Law Judge Linda F. Nelson on August 12, 2022, in Fayetteville, North Carolina.

APPEARANCES

For Petitioner:
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For Respondent:
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APPLICABLE STATUTES AND RULES

North Carolina General Statutes § 131E-256, § 150B-1, *et seq.*; and 10A N.C. Admin. Code 13O .0101(1) and 13O .0101(10) (incorporating by reference 42 C.F.R. § 488.301).

WITNESSES

For Petitioner: Shirley J. Spears

For Respondent: James Harris, Director of Quality Management for Victor & Associates, Inc.
Melissa Russo, Health Care Personnel Investigator for Respondent

EXHIBITS

For Petitioner:

Petitioner's Exhibit 1, Photograph of M.B.'s Scars
Petitioner's Exhibit 2, 10/11/21 Incident Report Pages 2 and 3
Petitioner's Exhibit 3, Text Message
Petitioner's Exhibit 4, Dismissal of Criminal Charges

For Respondent:

Respondent's Exhibit 1, 10/15/21 IRIS Report
Respondent's Exhibit 3, Victor & Associates Employee Handbook
Respondent's Exhibit 5, Time Sheets for Petitioner and other Paraprofessionals
Respondent's Exhibit 6, Victor & Associates Policy and Procedures Manual
Respondent's Exhibit 7, Victor & Associates Employee File for Petitioner
Respondent's Exhibit 8, Training and In-Service Documentation
Respondent's Exhibit 9, Russo Interview with Harris
Respondent's Exhibit 10, Russo Interview with Petitioner
Respondent's Exhibit 11, 11/2/21 and 1/18/22 Letters from Russo to Petitioner
Respondent's Exhibit 12, Investigation Conclusion Report
Respondent's Exhibit 13, 10/11/21 Incident Report, Page 1

ISSUE

Whether Respondent deprived Petitioner of property or otherwise substantially prejudiced Petitioner's rights and exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule when it substantiated the allegations that Petitioner abused and neglected a resident at Harmony Home in Dunn, North Carolina, on October 11, 2021.

PROCEDURAL BACKGROUND

1. By letter dated January 18, 2022, Respondent notified Petitioner that Respondent had investigated and substantiated allegations that Petitioner abused and neglected a resident at Harmony Home in Dunn, North Carolina on or about October 11, 2021, and that Respondent would enter findings on the Health Care Personnel Registry as follows:

> On or about 10/11/2021, Shirley Jean Spears, a Health Care Personnel, abused a resident (M.B.) by willfully hitting the resident resulting in physical harm.
>
> On or about 10/11/2021, Shirley J. Spears, a Health Care Personnel, neglected a resident (M.B.) by failing to properly intervene with resident (MB) during a behavior, necessary to avoid physical harm.

2. On February 15, 2022, Petitioner filed a Petition for a Contested Case Hearing (the "Petition") appealing Respondent's decision to substantiate allegations that Petitioner abused and neglected a resident of Harmony Home on October 11, 2022 and place such findings next to Petitioner's name on the Registry.

FINDINGS OF FACT

UPON CONSIDERATION of the sworn testimony of the witnesses presented at the hearing, the exhibits admitted into evidence, and the entire record in this proceeding, after having weighed the evidence presented and assessed the credibility of witnesses by considering the appropriate factors for judging credibility, including, but not limited to, the demeanor of the witnesses, 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, the Undersigned finds as follows:

Parties and Witnesses

1. Respondent, North Carolina Department of Health and Human Services, Division of Health Service Regulation, is an administrative agency of North Carolina subject to the North Carolina Administrative Procedure Act. Respondent is statutorily required to maintain the health care personnel registry (the "Registry") which contains "the names of all health care personnel working in health care facilities in North Carolina" against whom Respondent substantiates neglect, abuse, misappropriation of property, diversion of drugs, or fraud. N.C. Gen. Stat. § 131E-256(a)(1).

2. Petitioner, Shirley J. Spears, was employed by Victor & Associates, Inc. ("Victor"), beginning in 2020, to work at Harmony Home, located in Dunn, North Carolina (the "Facility"). The Tribunal found Petitioner to be a credible witness.

3. Petitioner's job duties qualified her as "health care personnel" under N.C. Gen. Stat. § 131E-256(c). "Health care personnel" is unlicensed staff of a health care facility with direct access to a resident or client. Those holding this position are referred to herein as "paraprofessionals."

4. There is no evidence of any prior allegations of abuse, neglect, or exploitation against Petitioner.

5. The Facility is a "health care facility" subject to the provisions of N.C. Gen. Stat. § 131E-256. The Facility is owned and operated by Victor.

6. Respondent called James Harris, Director of Quality Management for Victor, as a witness. Mr. Harris investigated the allegation by Facility resident M.B. that she was beaten by Petitioner. Mr. Harris' investigation ran from October 13 - 18, 2021. Mr. Harris filed an Incident Response Improvement System Report (the "IRIS Report") with Respondent on October 15, 2021.

7. Mr. Harris also prepared a Client Rights Investigation Summary, dated December 9, 2021 (the "Harris Summary"), which was submitted to Respondent on December 14, 2021. Mr. Harris referred to the Harris Summary during his testimony. With the exception of a single page, Respondent declined to enter the Harris Report into evidence. Due to inconsistencies in his testimony and the shortcomings of his investigation, the Tribunal did not find Mr. Harris' testimony credible.

8. Respondent also called Melissa Russo, a Nurse Consultant for Respondent who performs health care personnel investigations for Respondent, as a witness. Ms. Russo investigated M.B.'s allegation for Respondent and prepared the Investigation Conclusion Report, dated January 18, 2022 (the "Russo Report"). The Tribunal finds that Ms. Russo's conclusions that Petitioner beat and neglected to safeguard M.B. are the product of a flawed investigation.

The Injured Party

9. At the time of the incident, M.B. was a resident at a facility owned by Victor referred to herein as "Andrews Drive." She was admitted to Victor's care in July 2021. M.B. first started spending occasional nights at the Facility in late August 2021. (Res. Ex. 8). She spent nights at the Facility rather than Andrews Drive when there were not enough beds at Andrews Drive or the personnel necessary to handle her behaviors. (Res. Ex. 8 and Ex. 12 pp. 26, 176, 198).

10. M.B. was diagnosed with bipolar disorder with dependent personality and mild intellectual developmental disabilities. (Res. Ex. 7). M.B. used a walker, had difficulty controlling anger, and displayed behaviors of physical and verbal aggression, which included cursing, making threats of harm toward staff and fellow clients, faking falls, kicking, spitting, punching, biting, striking others with her walker, self-injury, threatening to have staff fired, and threatening to commit suicide. (Res. Exs. 7 and 12).

The Incident

11. On October 10, 2021, Petitioner worked at the Facility on the second shift. M.B. spent the prior night of October 9, 2021 at Andrews Drive.

12. Shortly after Petitioner's October 10 shift concluded at 11:00 pm and she had returned home, Petitioner received a phone call from Sandra Wise, the third shift paraprofessional at the Facility who had relieved Petitioner. Ms. Wise was crying and told Petitioner she must return to work since Ms. Wise could not handle M.B.'s behaviors. Petitioner informed Ms. Wise that she could not work without the approval of the Victor Director of Operations, Vidya Persad. Ms. Wise told Petitioner that Ms. Persad required Petitioner to return to the Facility and take over Ms. Wise's shift.

13. Petitioner did not receive a call from Ms. Persad confirming Petitioner was required to return to work but relied on Ms. Wise's statement.

14. When Petitioner arrived back at the Facility at midnight, Ms. Wise was still crying and was unable to describe what had happened. Petitioner could hear M.B. screaming and yelling in one of the bedrooms.

15. Ms. Wise then went home, leaving Petitioner as the sole staff member at the Facility.

16. Ms. Wise never filed an incident report to document M.B.'s behavior during the hour that Ms. Wise worked on October 10, 2021 and was never asked to do so by Victor management. Ms. Wise was not questioned by Mr. Harris during his investigation.

17. Petitioner had been instructed by Ms. Persad not to intervene when M.B.'s cursed loudly at night, as long as M.B. remained in her room. Petitioner followed this instruction until she heard a banging noise coming from the room M.B. was in.

18. Upon entering the room, Petitioner observed M.B. holding a white clothes hanger, which M.B. was using to hit the glass top of a dresser. Petitioner thought that M.B. might break the glass and injure herself.

19. When M.B. brought the hanger up to hit the glass again, Petitioner took the clothes hanger from her. M.B. then lunged forward and hit the bedroom wall, creating a hole. Petitioner placed herself between M.B. and the wall to prevent M.B. from striking it again.

20. M.B. then threw herself backward from her walker to the bedroom floor. On the floor, M.B. kicked, flailed her arms, screamed, and cursed. M.B. told Petitioner that M.B. would break her car window, scratch Petitioner's car, burn down the Facility, and get her fired.

21. M.B. thrashed about on her back, striking the floor and the bed many times. Petitioner attempted to move the bed away from M.B. but it was too heavy.

22. After some time, M.B. calmed down, pulled herself off the floor using her walker, and sat on her bed. Petitioner then left M.B.'s bedroom.

23. Petitioner did not call her supervisor to report the incident. The supervisor that night was Ms. Persad, the supervisor of the Qualified Personnel, who would usually be the supervisor of paraprofessionals. Ms. Persad is the wife of the owner of Victor and the Director of Operations for all Victor facilities.

24. Later that evening, Petitioner heard a door alarm, indicating that someone had exited the Facility. Petitioner went to the backdoor and observed M.B. standing outside. Petitioner redirected M.B. into the Facility and into her bedroom, where M.B. went to sleep.

25. When Petitioner woke M.B. to prepare her for her day, M.B. asked Petitioner not to report her behavior during the incident to Ms. Persad and another paraprofessional who worked for Victor, Daphne Williams. M.B. said she would lose her privilege of going to Cracker Barrel on the following weekend. Petitioner informed M.B. that she had to report the incident.

26. M.B. was cooperative with Petitioner and showed no unease while Petitioner help her prepare for the day.

27. During the morning of October 11, 2021, Petitioner documented the incident, first by writing on a single page incident report form provided by the Facility for this purpose. (Res. Ex. 13). Petitioner found she did not have enough room on the form to fully describe the incident, so she wrote another page and one-half on plain lined paper. (Pet. Ex. 2, Res. Ex. 12). Petitioner wrote "full report" at the top right of the first of these two addendum pages.

28. Petitioner testified that she did not notice any new markings or bruises on M.B. No evidence has been admitted in this case to allow the Tribunal to determine whether marks would have been visible on M.B. before 8:00 am on October 11, 2021, if the bruises found on M.B. were the result of injuries sustained in the early morning hours of October 11, 2021.

29. It is not clear how the three-page incident report eventually ended up in Mr. Harris' possession at Victor headquarters sometime after October 13, 2021. Petitioner told Ms. Russo that she had completed only a draft of the report (it contains carats with inserted phrases) and was not sure what happened to it. She assumed that she had placed it on a bed in the Facility near papers that the paraprofessional working the first shift, Daphne Williams, had placed there, and that Ms. Williams took it.

30. Petitioner's testimony was not consistent with the account she gave Ms. Russo. At the hearing, Petitioner said that she followed the normal routine at the Facility and placed the incident report in a manilla envelope on the desk in the Facility. If the normal course of practice followed, the first shift paraprofessional would then pick it up and delivery to the Victor day facility referred to as MCI. From there it would be transferred to the Victor main office where it would go to the supervisor of the paraprofessionals and to Mr. Harris.

31. Petitioner informed Ms. Williams of M.B.'s behaviors when Ms. Williams arrived to relieve her at 8:00 am, October 11, 2021. Ms. Williams took a photograph of the hole that M.B. punched in the wall and sent it to Ms. Persad before taking the residents to MCI. Ms. Williams did not report seeing any bruises or marks on M.B.

32. Petitioner testified that she did not phone Ms. Persad to talk about the incident having been asked by Ms. Persad not to call while she was getting her children ready for school. Petitioner admitted that she usually called supervisors after incidents. Petitioner told other investigators that she did not have her phone on her. (Res. Ex. 12).

Days Following the Incident

33. M.B. spent the next evening and night of October 11, 2021, at the Facility. Petitioner provided care for M.B. at the Facility from 5:30 pm to 9:00 pm, and from 11:00 pm to 8:00 am, the morning of October 12, 2021. (Res. Ex. 5). She reported that M.B. had no problems.

34. The record is not clear in which facility M.B. spent the evening of October 12, 2021.

35. On October 13, 2021, a paraprofessional working with M.B. at MCI, Phyllis Colquit, noticed a bruise on M.B.'s neck as M.B. bent her head down to eat lunch. Ms. Colquit showed the bruise to another paraprofessional working at MCI, Shonda McLaughlin. (Res. Ex 12).

36. Mses. Colquit and McLaughlin asked M.B. how she got the bruising. M.B. replied that she had been beaten by Petitioner at the Facility with a white clothes hanger. Ms. McLaughlin phoned Ms. Persad to inform her of the bruises, and at her direction, took pictures of the bruises and sent them to Ms. Persad. (Res. Ex. 12, pp. 31, 39).

37. None of the paraprofessionals identified in the record as seeing M.B.'s bruising on October 13, 2021, and hearing M.B. say that they were caused by Petitioner beating her with a white hanger testified at the hearing. All accounts agree that no staff member reported marks on M.B. prior to Ms. Colquit discovering the bruises at lunchtime on October 13, 2021.[1]

38. Ms. Persad informed Mr. Harris of M.B.'s allegation after receiving the phone call from Ms. McLaughlin. (T. p. 11).

39. Petitioner was placed on leave at 10:15 pm on October 13, 2021. (Res. Ex. 5).

40. On the evening of October 13, 2021, M.B. told Mr. Harris, in the presence of Ms. McLaughlin, that Petitioner hit her with both a white clothes hanger and a blue tennis shoe. Ms. McLaughlin noted that this was the first time M.B. mentioned being beaten with a tennis shoe. (Res. Ex. p. 32).

41. On or about October 14, Petitioner was informed by Ms. Persad that she had not received the incident report prepared by Petitioner on the morning of October 11, 2021. Petitioner suggested Ms. Persad ask Ms. Williams what she did with the incident report. Ms. Persad instructed Petitioner to write another. Petitioner's reproduced report, which she dated October 14, 2021, was on two pages of ruled paper. This second report is consistent with the original incident report. (Res. Ex. 12, p. 176).

42. M.B. was examined by a doctor on October 14, 2021. The Russo Report included a summary of the medical examination. Ms. Russo's summary of the medical examination report notes bruises, including to M.B.'s head. The report also stated that the bruises were consistent with M.B.'s account of being beaten. This statement by the doctor is inadmissible hearsay and illustrates the unreliability of hearsay. The doctor apparently was not asked to opine if the bruises were consistent with any other scenario, such as that reported by Petitioner. Also, the doctor apparently was not told the date of the alleged beating, and thus did not consider whether the state of healing of the bruises was consistent with a beating 3.5 days earlier. Finally, it is not known what account M.B. gave to the doctor. M.B. reported to Ms. Russo that Petitioner struck her only

[1] Mr. Harris reported that Ms. Colquit first noticed the bruising on M.B. when Ms. Colquit was preparing M.B. in the morning of October 13, 2021, at Andrews Drive. He also reported that Ms. McLaughlin noted the bruising independent of Ms. Colquit. (e.g., Res. Ex. 12, p. 27). However, a review of the statements made by Mss. Colquit and McLaughlin and included in the record show that Ms. Colquit first noticed the bruises at MCI at lunchtime on October 13, 2021, and told Ms. McLaughlin about them. Ms. Colquit apparently was not working at Anderson Drive on the morning of October 13, 2021. (Res. Ex. 12, pp. 31, 38-9).

on the back of her neck and that Petitioner stuck her twice. (Res. Ex. 12, p. 24). Had M.B. related this account to the doctor, it is reasonable to expect the doctor would not have found the bruises on M.B.'s head, arms, back and legs consistent with M.B.'s account.

43. Petitioner was terminated by Victor on November 2, 2021. (Res. Ex. 12, p. 14).

44. Ms. Russo began her investigation for Respondent on November 2, 2021 and completed the Russo Report on January 18, 2022.

45. On August 4, 2022, criminal charges that were filed against Petitioner arising from the incident were dismissed. (Pet. Ex. 1).

The Original Incident Report

46. There is no evidence in the record of this case showing when, where, and by whom the missing original incident report was located. Mr. Harris testified only that he did not have the original incident report until after he started his investigation. It was included in the Harris Summary, but the only portion of the Harris Summary Respondent offered into evidence was the first page of the original incident report. (Res. Ex. 13). Petitioner entered the original additional pages of the incident report into evidence. (Pet. Ex. 2). Ms. Russo included the text of the October 11, 2021 incident report (missing the first page) and the October 14, 2021, incident report in the Russo Report. (Res. Ex. 12, pp. 72-3). Thus, both the entire incident report completed by Petitioner the morning of the incident and the text of the one prepared later as requested by Ms. Persad, are in evidence.

47. The Victor Operations and Management Policy and Procedure manual requires all Victor employees with first-hand knowledge of any "incidents, unusual occurrence or medication error" to document the same on an "incident report form" immediately following the incident. The manual provides further that the incident will be reported to "the supervisor, Director, parent/legal guardian, and treatment team as soon as possible after the occurrence (in no circumstance will this be more than 24 hours after the occurrence)." (Res. Ex. 6, Manual p. 20). The "Director" referenced in the manual is the Director of Quality Management, Mr. Harris.

48. The practice at the Facility at the time at issue in this contested case was for the third shift paraprofessional who prepares an incident report to place the incident report in an envelope labeled "incident report" on the desk in the Facility. The first shift staff member coming on duty would pick up the envelope and deliver it to the day program, which is referred to as MCI. From there, the envelope is taken to the Victor management offices or "main office." (T. p 173). According to Victor policy, the incident report is then transferred to "the supervisor, Director, parent/legal guardian, and treatment team" within 24 hours of the incident. (Res. Ex. 6, Manual p. 20).

49. In practice, the incident report is distributed to the supervisor within 24 hours of the incident documented therein, and then to the Director of Quality Management, Mr. Harris. The supervisor is responsible for informing the guardian of the resident involved in the incident. The

treatment team meets only quarterly and reviews the incident report at the time of its next meeting. (T. pp. 36, 59, 76).

50. Mr. Harris testified that the "immediate" supervisor for the paraprofessionals was a Victor employee, Stephen, whose surname Mr. Harris could not remember. Stephen was the qualified professional at the Facility at the time of the incident. Ms. Persad, the Director of Operations and wife of the owner of Victor, was the "next level" of supervisor. She would function as the supervisor if Stephen were not available. (T. pp. 61-62). Apparently, Stephen was not available at the time of the incident.

51. Mr. Harris stated several times that Petitioner did not follow the incident report policy of reporting the incident within 24 hours, and that the incident "was not reported at all until I began the investigations afterwards." (T. pp. 24, 36-37, 40, 56-57). When pressed about when Petitioner submitted the original incident report, Mr. Harris stated, ". . . I can only tell you that it was after I initiated the investigation when it showed up." (T. p. 85).

52. Mr. Harris did not attempt to explain how the original incident report "showed up" after he started his investigation and there is no evidence in the record about where it went after Petitioner prepared it on the morning of October 11, 2021.

53. As the practice at the Facility was for the third shift paraprofessional to leave the incident report for pick up by the first shift paraprofessional, the obvious person to confirm whether Petitioner completed the incident report at the proper time would be the first shift paraprofessional on October 11, 2021, Ms. Williams. Mr. Harris did not interview Ms. Williams.

54. Mr. Harris also did not attempt to confirm whether Ms. Persad received the picture of the hole in the wall that Petitioner asked Ms. Williams to send to Ms. Persad on the morning of October 11, 2021.

55. The Tribunal finds Mr. Harris' statement that Petitioner did not attempt to report the incident until after the investigation began on October 13, 2021, inconsistent with the evidence.

56. When Ms. Russo interviewed Ms. William more than three months after the incident, Ms. Williams stated she regularly picked up incident reports in the morning from the Facility and could not remember if she picked up one on October 11, 2021. Ms. Williams confirmed that, on a morning in October, Petitioner asked her to take a picture of a hole in the wall made by M.B. and to send it Ms. Persad. Ms. Russo did not follow up with Ms. Persad to determine if she received this picture and when. (Res. Ex. 12 p. 193-94, T. pp. 140-45).

The Harris Investigation and Testimony

57. As discussed above, Mr. Harris' assertion that Petitioner did not report the incident before the investigation began is not supported by the facts in the record. Indeed, when asked if Petitioner's "failure to report the incident promptly factor[ed] into your decision," he replied, "No, it did not factor into it." (T. p. 40).

58. Instead, Mr. Harris' conclusion that Petitioner beat M.B. rested on his finding that M.B.'s account was more reliable than Petitioner's: "So everything I talked with [Petitioner] about or what she shared was not consistent with the physical evidence, and the – I viewed the individual M.B. as highly credible." (T. p. 40).

59. The Tribunal did not get the opportunity to evaluate M.B.'s credibility, as she did not testify. The record shows that M.B. has cognitive and physical impairments and took many medications. The Tribunal recognizes that these impairments could render courtroom testimony an extraordinary burden for M.B., but the Tribunal cannot consider M.B.'s claims of abuse by Petitioner for the truth of the matter asserted because she did not testify.

60. Even if M.B.'s claims could be considered evidence that Petitioner beat M.B., Mr. Harris' assertion that M.B. was "highly credible" is not credible given M.B.'s medical diagnosis; M.B.'s reputation for untruthfulness, as discussed in paragraph 77, below; and the inconsistencies in her reports of the incident.

61. Mr. Harris reported that M.B. refused to discuss Petitioner's version of the incident when he attempted to interview M.B. a second time. Her failure to repeat the allegations in this context could be viewed as an inconsistency in her recitation of events. Mr. Harris' failure to follow up on M.B.'s refusal with a later attempt to discuss the matter suggests Mr. Harris did not have as much faith in M.B.'s ability to maintain her consistency as his testimony suggests. (Res. Ex. 12 p. 27).

62. Mr. Harris testified that M.B. did not report Petitioner beating her until more than two days had passed because she was afraid of Petitioner. Mr. Harris testified that there was no video to review. (T. p. 44). The Russo Report contains hearsay from a paraprofessional stating that there were cameras at the Facility. (Res. Ex. 12, p. 36). Video from the common areas of the house might have confirmed M.B. was fearful of Petitioner following the incident, as M.B. claimed. The Tribunal has only the evidence of Petitioner's testimony that M.B.'s demeanor did not change toward her. Ms. Russo's Report contains statements from other Victor paraprofessionals that M.B. had not changed or become generally untrusting or fearful. (Res. Ex 12 pp. 32, 40). The sole exception was Ms. Wise, who reported that M.B. became more distrustful of Ms. Wise following the incident. (Res. Ex. 12 p. 47). Thus, the Tribunal finds M.B.'s reason for not reporting the beating sooner is not credible.

63. M.B.'s statement s also inconsistent in that she did not include the charge that Petitioner beat M.B. with a tennis shoe until Mr. Harris interviewed her. Mr. Harris would have been aware of this inconsistency from the statements he took from Mses. Colquit and McLaughlin, but he does not seem to have considered this in evaluating M.B.'s credibility.

64. The Tribunal finds Mr. Harris' assertion that Petitioner's statements to him were not consistent with the physical evidence is not supported by the record, including Mr. Harris' own statements.

65. For example, Mr. Harris admitted that Petitioner consistently maintained that M.B. fell backwards during the incident. He acknowledged that M.B. had poor balance and had a behavior

of throwing herself to the floor but believed that her "injuries were not consistent with someone falling backwards" because she did not have "an injury at the head level." (T. p. 52). Yet in the IRIS Report, Mr. Harris wrote that M.B. had bruising on her head. (Res. Ex. 1). On December 15, 2021, Mr. Harris told Ms. Russo that M.B. had "bruising on the back of the head." (Pet. Ex. 9). The medical examination report of October 14, 2021, stated that M.B. had injury to the back of the head or "posterior scalp (occipital area)." (Res. Ex. 12 p. 87).

66. Mr. Harris testified that "management" did not approve Petitioner's working the third shift the night of the incident, creating a suggestion that Petitioner was untruthful in her claim that she followed policy and returned to work the night of the incident only because she was assured by Ms. Wise that Ms. Persad had required her return. (T. p. 25). Mr. Harris failed to interview Ms. Wise. (T. pp. 56, 61). Mr. Harris' explanation for his failure to interview Ms. Wise was that Ms. Wise had failed to complete an incident report, as required by Facility policy, so he had no reason to believe that Ms. Wise was aware of any bruising on M.B. when she left the Facility. (T. p. 67).

67. Mr. Harris stated Petitioner was inconsistent in reporting that she saw M.B. make the hole in the wall in the bedroom. Mr. Harris testified that when pressed on this, Petitioner changed her story and told him she had not seen M.B. make the hole. Petitioner is consistent in all other reports in the record that she saw M.B. make the hole and hearsay evidence from Ms. Williams confirms Petitioner told her that.

68. Finally, Mr. Harris testified that Petitioner's failure to note bruises on M.B.'s body within hours of the incident was another of Petitioner's reports inconsistent with physical facts. However, there is no evidence on the record to show that the bruises would have been visible if the injury had occurred shortly before Petitioner prepared her report. Also, no other paraprofessional who worked with M.B. reported seeing marks or bruises on M.B. until Ms. Colquit, two and one-half days after the incident.

The Russo Investigation and Testimony

69. The Russo Report, substantiating both abuse and neglect, were presented at the hearing as Respondent's Exhibit 12.

70. Ms. Russo concluded that Petitioner's recounting of events was not credible because Petitioner told "so many different stories." (T. p. 116). Ms. Russo did not provide examples of Petitioner's inconsistencies.

71. Ms. Russo testified that Petitioner told her that she "never submitted" the incident report. Ms. Russo did not appear to appreciate that the standard practice at the Facility was for the incident report to be picked up by the incoming first shift paraprofessional for delivery to MCI and future delivery to Victor headquarters for review by the supervisor. Therefore, Ms. Russo interpreted Petitioner's statement that Daphne Williams, the first shift paraprofessional on October 11, 2021, must have taken the report as a "story" made up by Petitioner to hide her failure to prepare a report, rather than an assertion by Petitioner that she assumed that Victor management received the incident report via the usual route.

72. Ms. Russo's testimony that Petitioner admitted that she did not attempt to inform her superiors of the incident which may have resulted in at least some of M.B.'s injuries is not supported by the record. (T. p. 116). Petitioner prepared the incident report, informed Ms. Williams of the incident in the morning, and asked Ms. Williams to send a picture of the damaged wall to Ms. Persad.

73. Ms. Russo failed to investigate any other possible sources of injury to M.B. M.B. was reported to have attempted to injury staff members, to have physical alterations with other Victor clients, and was alone with several other paraprofessionals before the bruising was reported.

74. Ms. Russo also did not investigate how the Facility could have gained possession of the original incident report if Petitioner had not submitted it.

75. Ms. Russo suggested Petitioner's failure to note bruises on M.B. the morning of the incident were indications of guilt. However, Ms. Russo did not consider why no other staff members reported bruises on M.B. during the two and one-half days following the incident and before the report which started Mr. Harris' investigation.

76. Further, Ms. Russo did not form a professional opinion or seek out a medical opinion on whether the state of healing of the bruises fit the time of the alleged beating or whether bruises incurred in the fall and thrashing around described by Petitioner would have been visible several hours later when Petitioner finished her shift on October 11, 2021.

77. The Tribunal also finds fault in Ms. Russo's failure to investigate the disparity of Ms. McLaughlin statements regarding M.B.'s credibility and Mr. Harris and Ms. Persad's. Mr. Harris and Ms. Persad told Ms. Russo that they were not aware of any unfounded accusations against staff made by M.B. However, Ms. McLaughlin told Ms. Russo that "[y]ou have to watch what M.B. says, she will fabricate things," and reported an incident in which M.B. made up a story about being pushed down by a staff member. (Res. Ex. 12 p. 31).

78. Ms. Wise confirmed to Ms. Russo that she had told Petitioner that Ms. Persad approved the change of staffing the night of the incident. (Res. Ex. 12 p. 45). However, Ms. Russo did not challenge Ms. Wise with Ms. Persad's contention that Ms. Wise did not approve the staff change. (Res. Ex. 12 p. 71).

79. Ms. Russo also did not question why Ms. Wise did not file an incident report on October 10, or why Ms. Wise was the only paraprofessional who stated that M.B. became distrustful of staff following the incident. (Res. Ex. 12 p. 47). Also of concern is that Ms. Wise was the only paraprofessional who stated that Petitioner was "stern" with residents. (Res. Ex. 12 p. 48). All others who knew Petitioner described her as kindly. (Res. Ex. 12 pp. 30, 34, 38, 44). Ms. Russo also failed to inquire whether Ms. Wise was crying uncontrollably the night of the incident as Petitioner maintained or just not feeling well as Ms. Wise stated. (Res. Ex. 12 pp. 43-49). A review of Facility videos taken that night in the common areas of the house might have resolved who was honest in this instance.

80. M.B. told Ms. Russo that she did not know Ms. Wise and that Ms. Williams rather than Ms. Wise had been the paraprofessional who worked for only an hour before the incident. (Res. Ex. 12 p. 24). Ms. Russo did not follow up with M.B. to try to determine if M.B.'s claim not to know Ms. Wise was motivated by fear of Ms. Wise or betrayed a faulty memory.

81. M.B. told Ms. Russo that Petitioner hit her twice. (Res. Ex. 12 p. 24). This would not account for the extensive bruising and should have led Ms. Russo to investigate further as to other possible causes of the injuries.

82. Finally, Ms. Russo did not interview Ms. Williams until three months after the incident. At that point, Ms. William could only confirm that she collected incident reports in the morning "all the time" and could not remember if she collected one the morning of the incident. Ms. Williams confirmed that Petitioner reported to her that M.B. had punched a hole in the wall and asked her to send the picture to Ms. Persad in October. Ms. Williams told Ms. Russo that she sent the picture to Ms. Persad that morning as Petitioner had stated. (Res. Ex. 12 p. 192-94).

83. Ms. Russo failed to follow up with Ms. Persad to discover when she received the picture of the hole in the wall from Ms. Williams.

84. Given the shortcomings of Ms. Russo's investigation into the cause or causes of M.B.'s injuries, the Tribunal finds that there is not adequate evidence to support a finding that Petitioner beat M.B.

85. The Tribunal also finds that there is little evidence that Petitioner neglected M.B. by failing to intervene to prevent harm to M.B. Petitioner testified that she attempted to keep M.B. safe and unharmed while M.B. exhibited her behaviors and the Tribunal finds Petitioner's testimony credible.

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter of this case 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 and nonjoinder.

3. All parties were properly noticed under N.C. Gen. Stat. § 150B-23.

4. To the extent that the Findings of Fact contain Conclusions of Law, or that the Conclusions of Law are Findings of Fact, they should be considered without regard to the given labels. *Charlotte v. Heath*, 226 N.C. 750, 755, 40 S.E.2d 600, 604 (1946); *Peters v. Pennington*, 210 N.C. App. 1, 15, 707 S.E.2d 611, 612 (1993).

5. Petitioner has the burden of proving that the Respondent agency erred in performing its duties pursuant to N.C. Gen. Stat. § 131E-256, substantially prejudicing Petitioner's rights. N.C. Gen. Stat. § 150B-25.1.

6. Respondent is required to maintain a registry containing the names of all health care personnel working in health care facilities in North Carolina who are subject to findings by Respondent that they abused, neglected, or exploited a resident in a North Carolina health care facility. N.C. Gen. Stat. § 131E-256.

7. The Facility is a "health care facility" as defined in N.C. Gen. Stat. § 131E-256(b).

8. "Health Care Personnel" means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. N.C. Gen. Stat. § 131E-256(c). At the time of the Incident, Petitioner was working as health care personnel.

9. By placing Petitioner on the Registry, Respondent has substantially prejudiced her right to work in the field which she has chosen and for which she has trained.

10. "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. . . . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." 42 C.F.R. § 488.301. This definition of abuse, as contained in the Code of Federal Regulations, is incorporated in 10A N.C.A.C. 13O.0101(1) by reference.

11. "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. This definition of neglect, as contained in the Code of Federal Regulations, is incorporated in 10A N.C.A.C. 13O.0101(10) by reference. Respondent maintains that the same act that supports a finding of abuse, the alleged beating of M.B. by Petitioner, also supports a finding of neglect because Petitioner did not render the services necessary to keep M.B. from physical harm.

12. The ALJ must decide the case only on the basis of the evidence presented and facts officially noticed, all of which are made part of the official record for purposes of administrative and judicial review. *N.C. Dep't of Env't & Nat. Res. v. Carroll*, 358 N.C. 649, 657, 599 S.E.2d 888, 893 (2004).

13. "In an administrative proceeding, it is the prerogative and duty of [the ALJ], once all the evidence has been presented and considered, to determine the weight and sufficiency of the evidence and the credibility of the witnesses, to draw inferences from the facts, and to appraise conflicting and circumstantial evidence. The credibility of witnesses and the probative value of particular testimony are for the [ALJ] to determine, and [the ALJ] may accept or reject in whole or part the testimony of any witness." *City of Rockingham v. N.C. Dep't of Env't. & Natural Res., Div. of Water Quality*, 224 N.C. App. 228, 239, 736 S.E.2d 764, 771 (2012).

14. Generally, the North Carolina Rules of Evidence, N.C. Gen. Stat. § 8C-1, *et seq*., govern OAH proceedings. N.C. Gen. Stat. § 150B-29 and 26 N.C.A.C. 03. 0122. The single exception to this general rule is for relevant evidence not "reasonably available under the rules." N.C. Gen. Stat. § 150B-29(a).

15. Hearsay is defined as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." N.C. Gen. Stat. § 8C-1, Rule 801(c).

16. N.C. Gen. Stat. 8C-1, Rule 802 prohibits hearsay except as allowed by statute, or that qualifies for an exception under Rule 803. In the case at hand, there is relevant evidence presented by Petitioner's credible testimony that she did not strike M.B in the early morning of October 11, 2022, as alleged by Respondent, which is not hearsay and thus "available under the rules."

17. Portions of the Russo Report contain statements by individuals who did not testify at the hearing. Accordingly, these statements constitute hearsay under the Rules of Evidence and may not be considered for the truth of the matter asserted. However, other portions of the Russo Report are admissible under Rule 803(8) as part of a public report resulting from an investigation made pursuant to authority granted by law.

18. The report of M.B.'s medical exam, to the extent that it describes the injuries to M.B. on October 14, 2022, are admissible under Rule 803(4) as statements for purposes of medical diagnosis or treatment.

19. The portions of the Russo Report not admissible for the truth of the matter asserted are the statements of M.B. and Victor staff who did not testify at the hearing and the statements of M.B.

20. Since there is relevant evidence admissible under the Rules of Evidence available to decide this case, that of Petitioner's testimony, the exception to the application of the Rules of Evidence found in Chapter 150B does not apply, and the Tribunal may not consider hearsay.

21. Based on the admissible evidence, the Tribunal holds that Respondent erroneously concluded that Petitioner abused M.B. by beating her and that Petitioner neglected M.B. by failing to act to safeguard her.

22. Even if the Tribunal were to consider the hearsay evidence offered, the Tribunal finds that the hearsay evidence bolsters both the credibility of Petitioner's testimony and Petitioner's statements as reported by Mr. Harris and Ms. Russo in their testimony and reports. The hearsay mainly reinforces the Tribunal's holding that Respondent erroneously concluded Petitioner abused and neglected M.B.

23. Petitioner satisfied her burden of proving by a preponderance of the evidence that Respondent substantially prejudiced her rights and acted erroneously and failed to act as required by law or rule or follow proper procedure when it substantiated the allegations that Petitioner

abused and neglected M.B. in the early hours of October 11, 2021 and entered those findings against Petitioner on the N.C. Health Care Personnel Registry.

FINAL DECISION

Based upon the Findings of Fact and Conclusions of Law, the Undersigned hereby REVERSES Respondent's substantiation of abuse and neglect against Petitioner and ORDERS Respondent to remove the substantiated findings against Petitioner's name from the North Carolina Health Care Personnel Registry.

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 16th day of December, 2022.

Linda F. Nelson

Linda F. Nelson
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 which subsequently will place the foregoing document into an official depository of the United States Postal Service.

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This the 19th day of December, 2022.

Christine E. Cline
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