


BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS  
STATE OF GEORGIA



MAR 14 2013

Petitioner, \*  
\*  
\*  
v. \* CASE NO.:  
\* OSAH-DCH-HFR-NAR  
DEPARTMENT OF COMMUNITY HEALTH, \*  
HEALTHCARE FACILITY REGULATION \*  
DIVISION, \*  
Respondent. \*

  
Kevin Westray, Legal Assistant

-Brown

INITIAL DECISION

I. Introduction

In response to a determination that a finding of abuse be placed next to Petitioner's name on Georgia's Nurse Aide Registry, Petitioner requested a hearing that was held on February 11, 2013.

For reasons indicated, Respondent's determination on April 10, 2012 to place Petitioner's name on the Georgia Nurse Aide Registry for abuse is REVERSED.

*This record is sealed to protect the name of any resident or the medical records of such a resident.*

II. Findings of Fact

1. In its October 1, 2012 letter to Petitioner, Respondent notified Petitioner of its determination that physical abuse occurred on August 15, 2012. Respondent alleged that Petitioner abused a resident after he became combative as she and another staff member were getting him out of bed. Respondent further alleged that the resident tried to hit her and that Petitioner responded by grabbing the resident by his wrists and holding them across his chest, shouting "I ain't putting up with it damn it." (Respondent Exhibit 1).

2. The resident referred to is a 78-year old male with diagnoses of Senile Dementia with depressive features, anxiety, Parkinson's Disease and unspecified behavior disturbances. He can become combative and did so on the morning of August 15, 2012 as Petitioner and another certified nursing assistant (CNA) attempted to clean him in his bed before getting him up from his bed into his geri-chair for breakfast. Petitioner explained the purpose of the care to the resident who is stiff and needs assistance to turn. As Petitioner and another staff member turned him on his side, he faced Petitioner and put his arms through the bed rail. I another staff member who was on the other side of the bed

began to clean him. As [redacted] did so, he became combative, and began hitting Petitioner with his arms that extended through the bed rails. Petitioner asked him to calm down and stop hitting her and attempting to hit [redacted]. He did not respond to her request. In order to keep him from hurting himself, she grabbed his wrists and got them back through the bed rails, and held them on his chest until he calmed down and they were able to clean a bowel movement that remained on him, transfer him to his geri-chair, and then roll him to the dining room for breakfast. (Testimony of Petitioner; Respondent Exhibits 5 and 6).

3. At an unspecified time on August 15, 2012, [redacted] reported to [redacted], LPN, her supervisor, that Petitioner was physically and verbally abusive toward the resident during morning care. [redacted] reported the matter to [redacted], LPN, the Risk Manager. Upon receiving the report, [redacted] promptly evaluated the resident. She noted red fading areas around both his wrists and that he was agitated. [redacted] inquired what was wrong. She recalls that he responded "yeah, she hurt me here" as he held up one of his wrists stating "made me mad." As Ms. [redacted] visited his room, another resident in an adjacent room reported that she overheard "one of the girls getting ugly with him." The other resident did not specify who "got ugly" and erroneously opined that one of them was her granddaughter who worked at the facility but was off that day. [redacted] so interviewed Petitioner and [redacted] whom she described as "tearfully" making her report. [redacted] s statement indicates Petitioner loudly stated to the resident, "I ain't putting up with that, damn it" as she restrained his hands to stop him hitting her. [redacted] walked off her job without notice shortly after the incident. Neither [redacted] or either resident appeared to give testimony. Petitioner does not recollect making the statement [redacted] reported during the investigation. (Testimony of Petitioner; Testimony of [redacted], LPN; Respondent Exhibits 4, 5, 6 and 7).

4. Although [redacted] observed redness on the resident's wrist, there was no subsequent bruising reported. There is no indication that the resident required any observation or analysis of his wrists other than the risk investigator's inspection whose perspective is that of a licensed practical nurse who is not trained to make medical diagnosis. Petitioner reported that the resident often "rang his wrists" making them red. The facility concluded that physical and verbal abuse was substantiated, terminated Petitioner's employment and reported the allegations to Respondent as required. Respondent conducted its investigation and issued its determination of physical abuse that Petitioner appealed. (Testimony of [redacted], LPN; Testimony of Petitioner; Respondent Exhibits 1, 2 and 3).

**III. Conclusions of Law**

*Nurse Aide Registry*

1. Each state participating in the Medicaid program must establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program. 42 U.S.C. § 1396r(e)(2)(A). The registry must include "specific documented findings by a state . . . of resident neglect or abuse, or

misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings." 42 U.S.C. § 1396r(e)(2)(B).

2. Each state is required to have a process for the receipt, timely review, and investigation of allegations against a nurse aide accused of neglect, abuse, or misappropriation of resident property of those individuals who are residents of a nursing facility. 42 U.S.C. § 1396r (g)(1)(c); 42 C.F.R. § 483.156(c)(iv). The Department of Community Health is the state entity responsible for the administration of this process and does so through its Healthcare Facility Regulation Division. The federal act further requires that a nurse aide has the right to rebut any such allegations of neglect, abuse, or misappropriation of resident property at a hearing. 42 C.F.R. § 335(c)(iii).

#### *Investigations*

3. The state must investigate every allegation of resident abuse, neglect, or misappropriation of property. Then, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut the allegations, the state must make a finding as to the accuracy of the allegations. If the state substantiates the allegation, the state must notify the nurse aide and the registry of such finding. 42 U.S.C. § 1396r(g)(1)(C); 42 C.F.R. § 488.335(a)(1) and (2). As applied, Respondent conducted an investigation and determined that Petitioner's name should be placed on the state's Nurse Aide Registry for physical abuse inasmuch as Petitioner grabbed Petitioner's wrist and said loudly, "I ain't putting up with that, damn it."

#### *Allegation of Abuse*

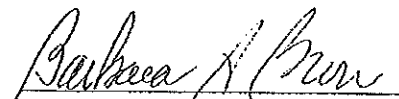
4. "Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. Respondent has the burden of proof in this matter and the standard of proof is a preponderance of the evidence. Ga. R. & Regs., rr. 616-1-2-.07 (1) and 616-1-2-.21 (4). Petitioner's intentions were clearly not malicious. Under circumstances described, the brief restraint to avoid injury to the resident and to Petitioner is reasonable. The redness to Petitioner's wrists did not result in a medical evaluation by a physician nor did it result in bruising. The mental anguish described is attested to only by the risk investigator. Especially given the resident's inclination toward combativeness, the resident's reported statement "yeah, she hurt me here [wrist shown] and "made me mad" may establish "pain" but it fails to establish that there was either physical harm or medical anguish as a result of Petitioner's responses to the resident's combativeness. Even if there was pain, Petitioner neither willfully inflicted injury to, unreasonably confined, intimidated or punished the resident with resulting pain. Review of the record as a whole supports a conclusion that Respondent has failed to meet its burden of proof. Ga. Comp. R. & Regs. r. 616-1-2-.07(1).

#### **IV. Decision**

Respondent's determination of abuse indicated in its *Order*, notice to Petitioner is **REVERSED**. Accordingly, Respondent is not authorized to place Petitioner's name and its finding

of abuse on the Georgia Nurse Aide Registry.

SO ORDERED, this 14<sup>th</sup> day of March 2013.

  
Barbara A. Brown  
Administrative Law Judge