BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

[redacted], Petitioner,	:	
	:	Docket No.:
v.	:	OSAH-DCH-HFR-NAR-1501921-67-Brown
DCH, HEALTHCARE FACILITY REGULATION DIVISION Respondent.	:	

FILED
OSAH
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Kevin Westray, Legal Assistant

INITIAL DECISION

I. Introduction

Petitioner, Mr. [redacted] appeals the decision of the Department of Community Health, Healthcare Facility Regulation Division (hereinafter "DCH" or "Respondent") to enter into the State Nurse Aide Registry a finding that he neglected a resident. The hearing on this matter was held as scheduled before the undersigned Administrative Law Judge of the Office of State Administrative Hearings (OSAH). Petitioner represented himself and Mr. Shariyf Muhammad, Esq., represented Respondent. For the reasons indicated herein, Respondent's decision to enter into the State Nurse Aide Registry a finding that Petitioner neglected a resident is **REVERSED**.

This record is sealed to protect the name of any resident or the medical records of such a resident. Release of any documents other than this decision or the notice on the Nurse Aide Registry can occur only upon review and redaction of the record. Neither Petitioner nor Respondent is authorized to utilize any documents exchanged pursuant to this litigation without redaction of the name of any resident referenced therein.

II. Findings of Fact

1. Petitioner is a Certified Nurse Aide (CNA) and, beginning in April 2013, was employed as a CNA Supervisor at Heritage Healthcare of Lilburn (hereinafter "Heritage Healthcare"), a nursing home facility, until he was terminated following the incident at issue in this Decision. *Respondent Exhibits 14, 16, and 17; Testimony of* [redacted]

2. One of the residents under Petitioner's care was "LJ", a thirty-two year old male admitted to Heritage Healthcare on July 21, 2013 with a primary diagnosis of end-stage renal disease. LJ used a wheelchair for mobility and required assistance from staff members to perform many activities of daily living. L.J. had no cognitive deficits; he was alert and oriented x 4 (person, place, time, and event) and able to make decisions concerning his care. *Testimony of Alonza Lewis; Exhibit R-13.*

3. On October 12, 2014 at approximately 1:00 p.m., April Moore, Activities Director at Heritage Healthcare observed LJ watching television in the dining room while the facility's cleaning crew was mopping the floor and disinfecting the area. Heritage Healthcare's policy forbids residents from occupying a room during cleaning operations because of the risk that the resident could inhale hazardous fumes generated by cleaning compounds or slip on a slick floor. Accordingly, Moore approached LJ and asked him to leave the dining room. LJ initially resisted Moore's instructions to leave, telling her that he wanted to watch football and that, on weekdays, the facility's staff always permitted him to watch television in the dining room while it was being cleaned. After Moore insisted, LJ became upset, but eventually complied with her instructions and left the dining room. *Respondent Exhibits 4, 6, and 9; Testimony of April Moore.*

4. Approximately fifteen minutes later, LJ approached the nursing station and complained to Nikki Patton, Assistant Director of Nursing, about being told to leave the dining area by Moore. Patton told LJ that Moore was correct and that he was welcome to return to the dining area after the cleaning crew had finished. She also offered LJ the alternative of watching television in the employee lounge. LJ declined and left the nursing station. *Respondent Exhibit 7; Testimony of Nikki Patton.*

5. Moore reported her contact with LJ to Petitioner, and requested that Petitioner tell LJ that he was not allowed to remain in the dining room while it was being cleaned. Petitioner spoke with LJ approximately one to two hours later, and explained that it was hazardous for him to stay in the dining area while the cleaning crew was mopping and disinfecting the area. LJ indicated to Petitioner that he understood. *Respondent Exhibits 6 and 9; Testimony of* [redacted] *Testimony of April Moore.*

6. At approximately 6:45 p.m., Petitioner observed that LJ was in the dining room watching television. One member of the cleaning crew, Irma Martinez, had started mopping the dining room floor. After telling Martinez to cease mopping the floor, Petitioner approached LJ and told him to leave so that cleanup could resume. LJ was resistant to Petitioner's request, reiterating his earlier complaint that the weekday staff members allowed him to remain in the dining room during cleanup. Petitioner insisted that LJ had to leave the dining room and assured him that he could return and watch television after cleanup was complete. Petitioner attempted to reason with LJ for several minutes, but LJ still refused to exit the dining room. Eventually, Petitioner told LJ that if he did not exit the dining room, he would be wheeled out. When LJ still did not comply with Petitioner's requests, Petitioner attempted to wheel LJ out of the dining room. Because LJ resisted being wheeled out of the dining room in a forward direction by placing his feet on the floor, Petitioner turned the wheelchair around and wheeled LJ out of the dining room backwards. LJ continued to resist being wheeled out of the dining room and sustained an injury to his right forearm, apparently while attempting to stop the wheelchair with his hands. Petitioner eventually wheeled LJ out of the dining room and into the hallway. *Respondent Exhibits 3, 4, 5, 6, and 8; Testimony of LJ; Testimony of* [redacted]

7. LJ contacted his family members, who in turn contacted the facility and the police department. LJ also reported the incident to Necisse Stokes, a licensed practical nurse at Heritage Healthcare,

who thereupon conducted a physical assessment of LJ. LJ reported no pain or injury during the assessment, but later reported pain in his right forearm, which prompted Patton to order an x-ray. After an x-ray of the affected area proved inconclusive as to whether LJ had suffered a fracture, LJ was taken to the emergency room, where he was diagnosed with a contusion, but no fracture, to the right forearm. *Respondent Exhibit 4, 11, and 12; Testimony of Nikki Patton; Testimony of Necisse Stokes.*

8. Heritage Healthcare's Administrator, Alonza Lewis, commenced an investigation after he was alerted to the incident and immediately placed Petitioner on suspension. Lewis also reported the incident to DCH in a Facility Incident Report Form. During the course of his internal investigation, Lewis interviewed and obtained statements from Petitioner, LJ, Nikki Patton, Irma Martinez, and April Moore. *Respondent Exhibits 3, 4, 5, 6, 7, 8, 9, 11; Testimony of Alonza Lewis.*

9. In his written statement, LJ claimed that Petitioner directed profanity towards him during the incident. However, Petitioner denied using any profanity during the incident and the other individual who witnessed the incident, Martinez, did not recall Petitioner using profanity. Accordingly, Lewis was unable to verify LJ's claims of possible verbal abuse. *Respondent Exhibits 3, 4, 5, 6, 8; Testimony of LJ; Testimony of Alonza Lewis.*

10. Lewis concluded in his investigation that Petitioner's conduct in forcibly removing LJ from the dining room constituted a violation of the facility's rules and LJ's rights as a resident. Accordingly, Petitioner's employment with Heritage Healthcare was terminated on October 15, 2013. Lewis conveyed the findings of his investigation in a follow-up report to DCH on or about March 4, 2014. *Respondent Exhibits 4, 16, and 17: Testimony of Alonza Lewis.*

11. In a letter dated March 18, 2014, DCH notified Petitioner that it intended to place a finding of neglect next to Petitioner's name on the Nurse Aide Registry due to the October 12 incident. DCH's adverse action was based upon the findings of the above-described, which, it alleged, "confirmed that [Petitioner] forcefully removed a resident from the [dining] room that didn't want to leave and in the process neglected to avoid physical harm and mental anguish." Petitioner submitted a written hearing request on or about April 14, 2014 and the matter was referred to the Office of State Administrative Hearings for adjudication. *Respondent Exhibits 1 and 2.*

12. At the hearing of this matter, Petitioner testified that he removed LJ from the dining room out of concern for LJ's safety and pursuant to the facility's policy against residents remaining in the room while cleaning operations are underway. According to Petitioner, he felt at the time that LJ was in "immediate danger," and that he acted "in good faith" in removing LJ from the area. Petitioner further testified that he felt that he had exhausted all reasonable alternatives before attempting to wheel LJ out of the dining room. *Testimony of* [redacted]

13. Alonza Lewis acknowledged in his testimony that the October 12 incident presented Petitioner with a difficult situation and that Petitioner appropriately attempted to resolve the

situation by re-directing LJ with alternatives to remaining in the dining area. However, Lewis opined that Petitioner nonetheless acted inappropriately by forcibly removing LJ. In Lewis's opinion, Petitioner should have halted cleaning operations until LJ could be persuaded to leave the dining room. *Testimony of Alonza Lewis.*

14. Nikki Patton testified that certain circumstances, such as where the resident is in immediate danger, might justify removing a resident from an area by force. However, she posited that the appropriate course of action in situations such as the October 12 incident is to halt cleaning operations, continue to attempt to reason with the resident, and call for additional staff members to help if necessary. *Testimony of Nikki Patton.*

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), (2). As applied, Respondent conducted an investigation and determined that Petitioner's name should be placed on the state's Nurse Aide Registry inasmuch as Petitioner allegedly forcibly removed a resident from an area against his will and thereby "neglected to avoid physical harm and mental anguish."

Allegations of Neglect

4. "Neglect" is defined as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. This definition does not require the state to prove a resident suffered an actual injury in order to sustain a finding of neglect. Id. Respondent has the burden of proof in this matter and the standard of proof is a preponderance of the evidence. GA. COMP. R. & REGS. 616-1-2-.07(1), 616-1-2-.21(4). Based on this record and the testimony of the parties and witnesses, Respondent has failed to prove by a preponderance of the evidence that Petitioner neglected a resident. See OSAH Rules 7 and 21.

5. Respondent alleges that, by wheeling LJ out of the dining room against his will, Petitioner failed to provide services necessary to avoid physical harm and mental anguish. However, nothing in the evidentiary record indicates that removing a resident from an area against his or her will, in itself, constitutes neglect. Indeed, the Assistant Director of Nursing for the facility testified that, in some instances, removing a resident against his or her will is acceptable. As Mr. Lewis noted, the events of October 12, 2013 presented Petitioner with a difficult choice. His attempts to persuade LJ to leave had proved fruitless. If Petitioner opted to allow LJ to remain in the room after cleanup had commenced, he would be in clear violation of the facility's policy and LJ would be subject to continued exposure to potentially dangerous chemical fumes, or slipping/sliding on a wet floor. Petitioner may or may not have made the right decision in choosing to remove LJ from the area being sanitized, Respondent failed to show how Petitioner's departure from best practices was tantamount to neglect.

6. DCH has submitted insufficient evidence to show that Petitioner neglected LJ. DCH has therefore failed to demonstrate that its determination to place Petitioner's name on the Georgia Nurse Aide Registry is correct.

IV. Decision

In accordance with the foregoing Findings of Fact and Conclusions of Law, the Department's decision to place the Petitioner's name in the State Nurse Aide Registry is hereby **REVERSED**.

SO ORDERED, this 24th day of October, 2014.

Barbara A Brown

Barbara Brown
Administrative Law Judge