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OFFICE OF ADMINISTRATIVE HEARINGS
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STATE OF NORTH CAROLINA

COUNTY OF CLEVELAND

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
18 DHR 07276

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

BACKGROUND

This matter was heard before the Honorable David F. Sutton, Administrative Law Judge, on April 29, 2019, in Shelby, North Carolina.

APPEARANCES

For Petitioner: Audiasha Walker, *pro se*
521 East Warren St.
Shelby, NC 28150

For Respondent: Erin E. Gibbs
Assistant Attorney General
North Carolina Department of Justice
P.O. Box 629
Raleigh, N.C. 27602-0629

APPLICABLE STATUTES AND RULES

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

ISSUE

Whether Respondent deprived Petitioner of property or otherwise substantially prejudiced Petitioner's rights and failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule when it substantiated an allegation that, on or about August 4, 2018, Petitioner neglected a resident of Shelby Manor in Shelby, North Carolina.

EXHIBITS ADMITTED INTO EVIDENCE

Petitioner offered no exhibits into evidence. Respondent's Exhibits 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, and 12 were admitted into evidence.

WITNESSES

For Petitioner: Audiasha Walker

For Respondent: Audiasha Walker (called as an adverse witness)
Janie Burson
Vergia Strange
Denita Wyatt

FINDINGS OF FACT

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing, the documents, exhibits received and admitted into evidence, and the entire record in this proceeding, the undersigned Administrative Law Judge ("ALJ") makes the following Findings of Fact. In making these Findings of Fact, the ALJ has weighed the evidence presented and has assessed the credibility of the witnesses by taking into account 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.

Parties/Witnesses

1. Respondent, the Division of Health Service Regulation ("Agency" or "Division"), is a division of the North Carolina Department of Health and Human Services and an administrative agency of North Carolina state government operating under the laws of North Carolina. The Agency is statutorily required to maintain the health care personnel registry ("Registry" or "HCPR"), which contains "the names of all health care personnel working in health care facilities in North Carolina" against whom the Agency has substantiated neglect, abuse, misappropriation, diversion of drugs, or fraud. N.C.G.S. § 131E-256(a)(1).

2. Petitioner Audiasha Walker, at all times relevant to this matter, was employed as a personal care assistant at Shelby Manor Assisted Living in Shelby, North Carolina, ("Shelby Manor"), a health care facility subject to the provisions of N.C.G.S. § 131E-256.

3. Janie Burson is a personal care assistant, medication technician, and supervisor at Shelby Manor. (R. Ex. 8; T. 18). She has worked as a supervisor and medication technician for approximately twenty years and has worked at Shelby Manor for the past eleven years. (T. 18).

4. Vergia Strange is the Executive Director and Administrator at Shelby Manor. (R. Ex. 9; T. 25). She has worked in the health care field for twenty-seven years. (T. 25).

5. Denita Wyatt is a nurse consultant with the Health Care Personnel Complaint Intake Unit for Respondent. (T. 37–38). She has been a nurse for approximately sixteen years and has worked as a nurse consultant for Respondent for the past three years and as a surveyor for six years. (T. 38). Her job responsibilities include investigating unlicensed health care personnel in a western region of the state, including Cleveland County. (T. 38–39).

Background

6. Petitioner began her employment at Shelby Manor in April of 2018. (R. Ex. 4).

7. S.W. is a resident of Shelby Manor. She is in her mid-80s and suffers from dementia. She came to Shelby Manor in July of 2018 with a diagnosis of clostridium difficile ("c. diff"). (R. Ex. 11).

8. C. diff causes gastroenterological symptoms, including diarrhea, and is highly contagious, necessitating a contact precaution. (T. 19). Practically, the main difference, in caring for soiled residents with and without contact precautions, is a gown would be required when cleaning a resident with a contact precaution. (T. 44).

9. Improper incontinent care can cause skin breakdowns, which can lead to open sores, infections, sepsis, and death. (T. 47).

10. Shelby Manor provided employees with regular training on infection protocol and contact precautions throughout Petitioner's employment. (T. 21, 27). Prior to Petitioner beginning work, on April 9, 2018, Vergia Strange personally reviewed a list of policies and procedures with Petitioner, including those related to infection control and universal precautions, which Petitioner signed and dated. (R. Ex. 4; T. 28). On May 22, 2018, Petitioner attended and successfully completed an in-service training on infection control for adult care homes. (R. Ex. 5).

11. On the morning of August 4, 2018, Petitioner was assigned to work with S.W. (T. 13). As Petitioner was getting residents up for the day and seated for breakfast, another staff member alerted Petitioner that S.W. had had a bowel movement and soiled herself. (R. Ex. 2; T. 19-20).

12. Ms. Burson was alerted to the fact S.W. had soiled herself (R. Ex. 2, 9, 10; T. 13–14, 19–20) and directed Petitioner to clean S.W. (T. 13–14, 20).

13. Petitioner credibly testified that she had never cleaned a resident in the condition S.W. was in at the time she received Ms. Burson's direction, that she felt improperly trained to do so and that she was scared. Petitioner asked Ms. Burson to be able to assist another employee in cleaning S.W., however, Mrs. Burson did not provide help to Petitioner (T. 14). Petitioner then refused to clean S.W. (T. 15).

14. Ms. Burson was the only individual who testified at the hearing of this matter who was a witness to Petitioner's action of refusing to clean S.W. Ms. Burson testified that Petitioner claimed that she did not have proper training and refused to clean S.W. (T. 20).

15. Two other employees cleaned S.W. (T. 20). S.W. was not aware that anyone refused to clean her. (T. 27).

16. Ms. Burson then reported the incident to Ms. Strange, (T. 21–22) who gave Ms. Burson authority to send Petitioner home from work, which she did. (T. 26).

17. Petitioner remained suspended from her employment while Ms. Strange conducted a facility investigation into the incident with Petitioner and S.W. (R. Ex. 2; T. 26).

18. As part of her investigation, Ms. Strange spoke with Petitioner and interviewed the other staff present at the time of the incident. (T. 26–27).

19. At the conclusion of her investigation, Ms. Strange substantiated the finding that Petitioner refused to perform her job duties and terminated her employment at Shelby Manor on August 7, 2018. (T. 29; R. Ex. 6).

Registry Investigation

20. State and federal law require health care facilities to submit reports to various agencies, including Respondent, within twenty-four hours of allegations or incidents occurring within the facility. (T. 39). The facility then has five working days to investigate the incident or allegation and submit a report of its findings. (T. 39).

21. The facility submitted a 24-Hour Initial Report regarding this incident to Respondent (R. Ex. 1) on August 6, 2018. On August 7, 2018, it submitted its 5-Working Day Report summarizing the facility investigation. (R. Ex. 2).

22. Ms. Wyatt screened the allegation of neglect in the 24-Hour and 5-Working Day Reports and determined that it warranted an investigation. (T. 38, 39).

23. As part of her investigation, Ms. Wyatt reviewed the facility's investigation, Petitioner's personnel file, and S.W.'s records. (R. Ex. 11; T. 40).

24. Ms. Wyatt interviewed employees of the facility, including Ms. Strange, Ms. Burson, the two employees who cleaned S.W., and others who were working at the facility on the morning of August 4, 2018. (R. Ex. 8, 9, 10, 11; T. 40–41).

25. Ms. Wyatt was unable to conduct a formal interview with Petitioner, however, she did speak with Petitioner about the incident over the phone on two occasions, September 25, 2018, and October 29, 2018. (R. Ex. 10; T. 41).

26. Petitioner's statements to Ms. Wyatt on September 25, 2018 and October 29, 2018, were consistent with the testimony she provided during the hearing of this case. Petitioner expressed that she did not remember having training on infection protocol or contact precaution. Petitioner told Ms. Wyatt that she had never "done 'anything like this before,'" that she was scared and did not want to clean S.W. by herself and that Ms. Burson denied giving Petitioner help to clean S.W. (R. Ex. 10).

27. Ms. Wyatt interviewed Ms. Burson on September 25, 2018 regarding the August 4, 2018 incident. During this interview, Ms. Burson indicated that Petitioner flat out refused to go to S.W.'s room and provide care to S.W. (R. Ex. 8).

28. Ms. Wyatt completed her investigation and concluded that, on or about August 4, 2018, Petitioner neglected S.W. by failing to provide incontinent care. (R. Ex. 11; T. 47).

29. Neglect means "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." 10A N.C.A.C. 13O.0101(10); 42 CFR § 488.301.

30. There was no evidence submitted at the hearing of this matter that S.W. suffered any physical harm, pain, mental anguish, or emotional distress as a result of Petitioner's actions on August 4, 2018.

31. Respondent notified Petitioner via certified letter dated November 7, 2018, that it had substantiated the allegation of neglect and that a finding would be listed against her name in the Registry. (R. Ex. 12).

32. Petitioner filed a Petition for a Contested Case Hearing on November 28, 2018, challenging Respondent's substantiation of neglect.

CONCLUSIONS OF LAW

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

2. All parties have been designated correctly, and there is no question as to misjoinder or nonjoinder.

3. The North Carolina Department of Health and Human Services, Division of Health Service Regulation, Health Care Personnel Registry Section is required by N.C.G.S. § 131E-256 to maintain a Registry that contains the names of all health care personnel and nurse aides working in health care facilities who are subject to a finding by the Department that he or she abused or neglected a resident in a health care facility.

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

5. Shelby Manor is a health care facility as defined in N.C.G.S. § 131E-256(b).

6. "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." 10A N.C.A.C. 13O.0101(10), 42 CFR § 488.301.

7. Petitioner's refusal to clean S.W. on August 4, 2018, regardless of whether the refusal came after Ms. Burson refused to provide help to Petitioner or Petitioner refused to clean S.W. without asking for help, did not result in physical harm, pain, mental anguish, or emotional distress to S.W.

8. On August 4, 2018, Petitioner did not neglect S.W. because S.W. did not suffer physical harm, pain, mental anguish, or emotional distress as a result of Petitioner's refusal to clean her.

9. Petitioner had the burden to show by a preponderance of the evidence that Respondent deprived her of property or otherwise substantially prejudiced her rights and failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule. N.C.G.S. § 150B-25.1(a).

10. The preponderance of the evidence is that Respondent substantially prejudiced Petitioner's rights and failed to act as required by law or rule, when it substantiated the allegation of neglect and placed a substantiated finding of neglect against Petitioner's name on the Health Care Personnel Registry.

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

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the undersigned hereby determines that Respondent's decision to place a finding of neglect next to Petitioner's name on the Health Care Personnel Registry is **REVERSED**, and her name shall forthwith be removed from adverse citation in the Registry for this event.

NOTICE OF APPEAL

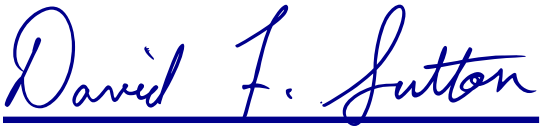
This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34.

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 29th day of July, 2019.



David F Sutton
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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This the 29th day of July, 2019.

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