12-2-2010

DEPARTMENT OF HEALTH ABUSE REGISTRY, Petitioner, vs. AGATHA NWOKEJI, Respondent

STATE OF TENNESSEE
DEPARTMENT OF HEALTH

IN THE MATTER OF:	)	
	)	
DEPARTMENT OF HEALTH	)	**ABUSE REGISTRY**
Petitioner,	)	
	)	
v.	)	**DOCKET NO. 17.38-109711J**
	)	
	)	
AGATHA NWOKEJI,	)	
Respondent	)	

INITIAL ORDER

This matter was heard on December 2, 2010 in Memphis, Tennessee, before Rob Wilson, Administrative Law Judge, assigned by the Secretary of State, Administrative Procedures Division, and sitting for the Commissioner of the Tennessee Department of Health. Maryam Kassaee, Assistant General Counsel, Office of General Counsel, Department of Health, represented the State. Respondent was present and was represented by James R. Becker, Jr., Esq.

The issue presented for consideration at this hearing was whether Ms. Nwokeji's name should be placed on the Tennessee Abuse Registry. After consideration of the testimony of witnesses, the evidence presented, the arguments of counsel, and the entire record, it is **DETERMINED** Ms. Nwokeji's name shall not be placed on the Abuse Registry. This decision is based upon the following finding of facts and conclusions of law:

FINDINGS OF FACT

1. Agatha Nwokeji was employed at Wesley Highland Manor Nursing Home for approximately two and a half months from June to August 2009.

2. Ms. Nwokeji has been employed as a certified nursing assistant for eight years, and she is currently employed at a nursing home.

3. The incident in question occurred on August 27, 2009, at Wesley Highland Manor Nursing Home, where Ms. Nwokeji was employed as a CNA.

4. Wesley Highland Manor Nursing Home used a video surveillance system to record the events of August 27, 2009.

5. Several employees of Highland Manor viewed the video and testified at the hearing as to what they saw on the video, but the video was deleted before the hearing date and was therefore not available to view during the hearing. The tape did not contain audio.

6. On August 28, 2009, Ms. Nwokeji's supervisor, Maria Graham, instructed Ms. Nwokeji and other employees to get all of the residents to the area in which their rooms were, and to move them away from an area where construction was occurring.

7. Ms. GP, an eighty-four year old woman, was one of the residents for which Ms. Nwokeji was responsible.

8. Ms. Graham was the RN supervisor at the time of the incident and had been a registered nurse for twenty years.

9. Ms. Graham testified that older patients tend to bruise easily and there is nothing unusual about Ms. GP that would cause her to not bruise more easily than a normal, healthy younger person.
Ms. Graham was the RN supervisor at the time of the incident and had been a registered nurse for twenty years.

10. Ms. Nwokeji began moving the residents for which she was responsible to their rooms. When she came to Ms. GP, she saw that the door through the construction area was closed.

11. Ms. Nwokeji testified that she helped Ms. GP out of her chair by pulling up on her pants because she did not want to bruise Ms. GP's hands.

12. Ms. Charlotte Pierce, administrator of the facility, testified that she watched the video of the incident and stated that she observed Ms. Nwokeji pulling Ms. GP up out of her chair by her hands.

13. There was no bruising noted on Ms. GP's hands after the incident.

14. In contrast to Ms. Pierce's testimony, State's witness Shirley Jennings testified that the first thing she saw that she considered to be inappropriately done by Ms. Nwokeji was "when she pushed her under the tape."

15. Ms. Jennings did not testify that she saw anything inappropriate in how Ms. Nwokeji got Ms. GP out of the chair.

16. Although the State characterized Ms. Nwokeji as "dragging" Ms. GP down the hall, Ms. Graham testified that there was no bruising on Ms. GP's hands or arms and that she "saw her not dragging her."

17. Ms. Graham's testimony was supported by Ms. Pierce, who testified that Ms. Nwokeji "wasn't dragging her."

18. State's witness Brooks Carpenter testified that the area through which Ms. Nwokeji moved Ms. GP had "bookshelves and books and chairs… [and the] whole area just jumbled with stuff."

19. By contrast, State's witness Derrick Hopson testified that the area leading up to the door had "no boxes or anything to…navigate around, other than just the tape.

20. Similarly, State's witness Shirley Jennings testified that there was no stuff piled up in front of the doors, and no boxes or bookcases.

21. State's witness Maria Graham, who also viewed the videotape, testified that she saw Ms. GP fall and that she saw another nurse, Mr. Derrick Hopson move Ms. GP through the door.

22. Ms. Nwokeji testified that she walked Ms. GP to the closed door and tried to help her get under the tape, but did not push her. Ms. Nwokeji further testified that she was standing face to face with Ms. GP and trying to open the door, but it would not open.

23. At that point, according to Ms. Nwokeji, she let go of Ms. GP and tried to open the door. At this point Ms. GP "scoot[ed] her feet," kneeled and sat down on the floor.

24. Mr. Hopson testified that he had witnessed that Ms. GP would let "her full body just [go to the ground]."

25. After Ms. GP was on the ground, Ms. Nwokeji got the door opened and called out to the other side to try and get someone to help her with Ms. GP.

26. Mr. Hopson testified that Ms. Nwokeji called him to come help her with Ms. GP.

27. Mr. Hopson further testified that when he got to her side of the door to help Ms. Nwokeji get the resident off the floor, he saw no other facility employee in the area.

28. The State presented no evidence that anyone was at the nurse's station on the side of the door where the incident occurred or in the area at the time of the incident.

29. By contrast, State's witness Charlotte Pierce testified after viewing the video that Ms. Nwokeji "stood there for a few minutes" until a "nurse came through the door and assisted the resident up and took her through the door."

30. When asked to clarify what she witnessed, Ms. Pierce was unable to state any time frame for how long Ms. Nwokeji "stood there," only that she felt Ms. Nwokeji made no effort to get Ms. GP off the floor, and she could not say that calling for help would constitute trying to get Ms. GP off the floor.

31. After assisting her up from the floor Ms. Nwokeji continued escorting Ms. GP to her room.

32. Directly after the incident Ms. Hopson observed that Ms. GP had a "steady gate" and did not appear to be "in any type of distress."

33. On the way to Ms. GP's room, Ms. Nwokeji told the charge nurse in the area about the incident.

34. Ms. Graham and Ms. Jennings assessed Ms. GP after the incident. Ms. Graham noted bruises on GP's right knee, leg, and thigh.

35. Ms. GP's doctor was notified of the incident and did not think it was necessary to do anything since Ms. GP showed no signs of distress or pain.

36. The nurse's notes for the period reflected that Ms. GP showed "no signs of distress or pain."

37. Ms. Nwokeji testified without contradiction that she did not intend to harm Ms. GP.

38. Ms. Graham also testified that she really did not think that Ms. Nwokeji was trying to harm Ms. GP.

39. There is no evidence that Ms. GP suffered any pain, discomfort, or injury.

40. The affirmative conduct alleged by the State includes Ms. Nwokeji "dragging" Ms. GP out of her chair and down the hall and attempting to push her under the tape which resulted in Ms. GP falling to the ground. The evidence did not prove the State's allegations.

41. The evidence did not show that Ms. Nwokeji failed to provide any good or service to Ms. GP which was necessary to avoid physical harm or mental anguish.

42. Wesley Highland Manor Nursing Home did not provide any service to Ms. GP after the incident other than to keep an eye on her.

CONCLUSIONS OF LAW AND ANALYSIS

The Code of Federal Regulations ("CFR") is utilized for determining when an individual is to be placed on the Abuse Registry. The CFR definition of abuse requires "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish," and the definition of neglect requires "the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. Under the Tennessee

Code, "abuse or neglect" means the infliction of physical pain, injury, or mental anguish, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult or a situation in which an adult is unable to provide or obtain the services that are necessary to maintain that person's health or welfare." T.C.A. § 71-6-102.

In this case, the State did not show that Ms. Nwokeji willfully inflicted any injury upon Ms. GP. Multiple witnesses testified that it did not appear that Ms. Nwokeji intended to harm Ms. GP. Additionally, multiple witnesses gave different accounts of what actually transpired between Ms. Nwokeji and Ms. GP, which leads to the conclusion that no one actually has a clear recollection of what happened on the day in question. The most troubling aspect of this case, however, is that a videotaped recording of the incident was made, and subsequently viewed by several people involved in the disciplinary process, but not preserved for the hearing. "Spoliation" is the destruction or significant alteration of evidence, or the failure to preserve properly for another's use as evidence in pending or reasonably foreseeable litigation. *Zubulake v. UBS Warburg LLC, 220 F.R.D. 212.* In *Zubulake*, the Court held that the obligation to preserve evidence arises when the party has notice that the evidence is relevant to litigation or when a party should have known that the evidence may be relevant to future litigation. In the instant case the videotape was viewed by Ms. Graham, Ms. Jennings, Ms. Pierce, and possibly others. Surely between an RN Supervisor, a Director of Nursing, and a Nursing Home Administrator, at least one of those people knew that Ms. Nwokeji could appeal her placement on the Abuse Registry, and that the videotape would need to be preserved for future litigation. Although it appears that the videotape was destroyed through ordinary negligence as opposed to bad faith, the fact remains that Wesley Highland Manor had an obligation to preserve the evidence, and the negligent failure to preserve such evidence supports an inference that the evidence would have been unfavorable to the party responsible (either negligently or intentionally) for its destruction. That inference is

supported in the instant case by the fact that the videotape could have possibly resolved the discrepancies between the witnesses accounts of what actually happened on the day in question.

Accordingly, it is DETERMINED that the State did not prove that Agatha Nwokeji inflicted physical pain, injury, or mental anguish on Ms. GP. Additionally, it is determined that the State did not prove that Agatha Nwokeji failed to provide services by a caretaker that were necessary to maintain the health or welfare of Ms. GP.

Based on the foregoing, it is CONCLUDED that the State of Tennessee has not carried its burden, and Ms. Agatha Nwokeji's name shall not be placed on the Abuse Registry.

This Order entered and effective this 24th day of March, 2011.

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Rob Wilson
Administrative Judge