3-21-2006

DEPARTMENT OF HEALTH, Petitioner, vs. PEGGY MICHELLE HUGHES, Respondent

BEFORE THE COMMISSIONER OF THE TENNESSEE DEPARTMENT OF HEALTH

IN THE MATTER OF:	)	
	)	
DEPARTMENT OF HEALTH,	)	
Petitioner	)	
	)	**DOCKET NO: 17.38-088257J**
v.	)	
	)	
PEGGY MICHELLE HUGHES	)	
Respondent	)	

ORDER

This contested administrative matter was heard on March 21, before James A. Hornsby, Administrative Judge, assigned by the Secretary of State, Administrative Procedures Division, and sitting for the Commissioner of the Tennessee Department of Health in South Pittsburg, Tennessee. Lucille F. Bond, Assistant General Counsel for the Tennessee Department of Health, was present and represented the State. The Respondent, Peggy Michelle Hughes, was present without counsel.

The matter became ready for consideration on May 18, 2006, when the transcript was filed.

The issue to be decided is whether the Respondent's name should be placed on the Registry of Persons Who Have Abused, Neglected or Misappropriated the Property of Vulnerable Individuals (Registry) as prescribed by Tennessee Code Annotated, §68-11-1001 *et seq.* After consideration of the record in this matter and the arguments of the parties, it is ORDERED that the Respondent's name NOT BE PLACED on the Department's Registry. This determination is based upon the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. During the time pertinent to this matter, the Respondent was employed as a Certified Nursing Assistant at Rivermont Care and Rehabilitation Center (Rivermont) in South Pittsburgh, Tennessee. She worked there from April 21, 1997, until August 10, 2005.

2. Rivermont provides in-patient nursing care for the elderly and infirm. Nursing Assistants assist residents with their daily living activities and monitor vital signs.

3. Upon becoming employed at Rivermont, the Respondent was formally instructed that she was obligated to respect the rights of residents and was not to abuse, neglect, or otherwise mistreat residents in any way. She was also instructed that the proper way to react to a combative resident is to walk away from the resident and seek help.

4. The Respondent is alleged to have abused five residents of Rivermont on August 7, 2005. At the hearing, and in the pleading of this matter, the residents were referred to by their initials. The five residents named in the State's Notice of Charges are J.H., M.S., B.O., E.K. and B.W. The State's witness concerning E. K. and B. W. did not appear to testify, and no proof of the allegations concerning them was presented.

5. Several members of the Rivermont staff testified at the hearing concerning the allegations involving the three residents, J.H., M.S. and B.O. Witnesses with first hand knowledge had widely differing recollections of the alleged incidents and of the Respondent's work in general.

6. The subject residents are all elderly, infirm and dependent on the assistance of the Rivermont staff for their daily living activities. The day of the alleged incidents, August 7, 2005, the Respondent was working the 7:00 a.m. to 3:00 p.m. shift along with several other Nursing Assistants. They were responsible for cleaning, dressing, feeding and otherwise caring

for the residents during that shift. Each Nursing Assistant was responsible for about 20 residents.

7. The Respondent delivered breakfast trays to the rooms of residents who could not ambulate to the dining room. She took a breakfast tray to resident J.H. This resident requires help eating, but he will not allow some people to feed him. Sometimes he throws his food into the trash can or on the floor. On this day, he would not let the Respondent feed him, so she took his tray away and went on to feed other patients. She later gave J.H.'s tray to another Nursing Assistant who was able to feed him. At that time, J.H. indicated that he was hungry and ate all his food.

8. A co-worker reported the Respondent to her supervisor for not feeding J.H. and also for allowing J.H. to wear a diaper when that was contrary to his treatment plan. However, other witnesses who work at the facility and are familiar with J.H testified that he is consistently allowed to wear diapers.

9. The next resident for which complaints were made that day is M. S. She is another elderly person who needs a lot of assistance. On that day she had a rash on both her legs. There was testimony that an aeration "wrap" had been prepared for her legs by a physical therapist and that the Respondent did not apply the wrap. The testimony was that M.S. was left in bed, in a wet diaper and confining sweat pants that were harmful to her rash. However, there was equally competent and believable testimony that no wrap had been prepared for her, and that even if it had been prepared, a therapist would have applied it, not a Nursing Assistant. There was also competent testimony that M.S. was continent at that time and could go to the bathroom by herself, that she could dress herself and that on that day she was in a chair, wearing a housedress, and not wearing a diaper.

10. There was testimony from the Nursing Assistant who relieved the Respondent at the change of shifts on August 7, 2005. She testified that she found the resident B. O. with feces on her bottom and under her fingernails.

11. On that day, the Respondent, in addition to her regular duties, was assigned to the dining room during the lunch meal. She provided meal trays to the residents in the dining room and assisted the residents who needed help eating.

12. It was typical for one Nursing Assistant to be assigned to the dining room during meals, and the Respondent expected that other Nursing Assistants would have delivered all the meal trays to the residents eating in their rooms. However, when she returned from her dining room duties, she found that her trays had not been given to the residents assigned to her. She had to begin delivering the trays and feeding the residents who could not feed themselves. This put her behind in taking care of other patients.

13. There was testimony from Rivermont administrators that the Respondent had received disciplinary actions at the facility on two occasions prior to August 7, 2005, but there was no proof of the alleged incidents that resulted in such actions. Also, the prior incidents are not on the State's Notice of Charges and therefore cannot be considered except as proof that the Respondent had been previously counseled concerning patient care. There was testimony from co-workers that the Respondent took too many breaks and did not take good care of patients, but there was equally competent and believable testimony that she did a good job and did not take any more breaks than others.

CONCLUSIONS OF LAW

1. Tennessee Code Annotated §68-11-1001(a), provides that, "The Department of Health and Environment shall establish and maintain a registry containing the names of any

persons who have been determined to have abused or intentionally neglected elderly or vulnerable individuals."

2. "Abuse or neglect" is defined in T.C.A. §71-6-102(1) as "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 which are necessary to maintain that person's health or welfare."

3. It is DETERMINED that the State has not proven by a preponderance of the evidence that the Respondent abused the subject residents at Rivermont Case and Rehabilitation Center and also DETERMINED that the Department is not authorized to place the Respondent's name on the Registry.

4. The State is unable to prove that the Respondent was routinely negligent to the residents in her care. Although witnesses testified that the Respondent was negligent in her care of the residents J.H. and M.S., equally competent witnesses testified that the Respondent was not at all negligent. The incident of resident B.O. having feces on her bottom and under her fingernails was proven, but the Respondent had a reasonable explanation of why she was not as attentive to B.O. as she should have been. No injuries or specific harm from the alleged incidents was shown or documented in the subject residents' records. That does not mean that the Respondent dealt with the residents properly as required by the policies of patient care at Rivermont, and her termination from employment may well be appropriate. But her termination is irrelevant to the issue of whether the proven incident is so egregious as to require her name to be placed on the abuse registry. It is DETERMINED that the incident does not rise to the level of abuse as anticipated by the law.

Therefore, it is ORDERED that the Respondent's name NOT be placed on the Registry of Persons Who Have Abused or Intentionally Neglected Elderly or Vulnerable Individuals and further that it be expunged from any reports made under T.C.A. 68-11-1006.

This Initial Order entered and effective this 10th day of July 2006.

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James A. Hornsby
Administrative Judge

Filed in the Administrative Procedures Division, Office of the Secretary of State, this 10th day of July 2006.

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Charles C. Sullivan II, Director