



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

DECISION

Morse, Peggy

ML-10-0122

Pursuant to petition filed March 9, 2010, under Wis. Stat. § 146.40(4r)(d) (2007-08) and Wis. Admin. Code § DHS 13.05(7) to review a decision by the Department of Health Services to review a decision by the Wisconsin Department of Health Services [DHS] to place a finding of neglect in petitioner's name on the Caregiver Misconduct Registry, a hearing was held on June 8, 2010, at Madison, Wisconsin.

The issue for determination is whether the petitioner committed “neglect” as defined by the state’s caregiver registry law.

There appeared at that time and place, the following persons:

PARTIES IN INTEREST:

Petitioner:

Morse, Peggy, by

Neil Rainford, Staff Representative
AFSCME AFL-CIO Council 40
8033 Excelsior Drive, Suite B
Madison, WI 53717-1903

Respondent:

Department of Health Services, by

Attorney John Tedesco
Department of Health Services
Office of Legal Counsel
P. O. Box 7850
Madison, WI 53707-7850

Administrative Law Judge:

Thomas H. Bround

Division of Hearings and Appeals

FINDINGS OF FACT

1. For the time in question and for the previous 25 years or so petitioner was employed by Columbia Health Care Center (facility) as a Certified Nursing Assistant (CNA).
2. On December 6, 2009 petitioner transferred a resident out of her bed into a wheelchair by herself. She then took the resident to the end of the bed and helped the resident out of the wheelchair and attempted to place a commode under her for toileting purposes.

3. During the process the resident fell and fractured her kneecap.
4. Petitioner did not put a gait belt on the resident before the accident occurred.

DISCUSSION

In nurse aide neglect cases the burden is on DHS to show reasonable cause to believe both: (1) that the alleged conduct actually occurred; and, (2) that the alleged conduct meets the definition of "neglect" found at section HFS 13.03(14) of the Wisconsin Administrative Code. If after the presentation of evidence the Administrative Law Judge ["ALJ"] finds that there is no reasonable cause to believe that the CNA neglected a resident, the CNA's name will not be entered in the registry. If the ALJ finds that there is reasonable cause to believe that the CNA neglected a resident, the CNA's name will be entered in the registry. Wis. Stat. § 146.40(4r)(d) (2007-08); Wis. Admin. Code §§ DHS 13.05(7)(d)5. & 6. (November 2008); *Kennedy v. DHSS*, 199 Wis.2d 442, 450 & 451, 544 N.W.2d 917 (Ct. App. 1996).

"Reasonable cause" means that the greater weight of evidence provides a reasonable ground for belief that the individual committed the act as alleged. Wis. Admin. Code § DHS 13.03(17) (November 2008).

The legal definition of the term "neglect" contains several sections. See, Wis. Admin. Code § DHS 13.03(14) (November 2008). The complete definition of "neglect" is as follows:

"(14) (a) "Neglect" means an intentional omission or intentional course of conduct by a caregiver or nonclient resident, including but not limited to restraint, isolation or confinement, that is contrary to the entity's policies and procedures, is not part of the client's treatment plan and, through substantial carelessness or negligence, does any of the following:

1. Causes or could reasonably be expected to cause pain or injury to a client or the death of a client.
2. Substantially disregards a client's rights under either ch. 50 or 51, Stats., or a caregiver's duties and obligations to a client.
3. Causes or could reasonably be expected to cause mental or emotional damage to a client, including harm to the client's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward behavior, agitation, fear of harm or death, or a combination of these behaviors. This paragraph does not apply to permissible restraint, isolation or confinement implemented by order of a court or as permitted by statute.

(b) 'Neglect' does not include an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance as the result of inability, incapacity, inadvertency or ordinary negligence in isolated instances, or good faith errors in judgment or discretion."

Wis. Admin. Code § DHS 13.03(14) (November 2008).

A gait belt is a canvas device with a buckle that is to be put around the waist of certain residents of the facility to help in controlling the movement of the resident. It provides something substantial for staff to hold on to to help stabilize a resident. The policy of the facility was that gait belts must be used on all residents who require assistance of staff to stand, transfer or ambulate. (Ex. 1) The facility's Standards of Care dictate that a gait belt must be used for all one/two person assist transfers whether or not the requirement is in the individual care plan. (Ex. 2)

The resident had a stroke in December 2007. As a result the right side of her body did not function. Her care plan required that she have two staff assist her when she was transferred from the bed to a wheelchair or commode. Clearly she met the facility's definition of a person who required a gait belt when being transferred.

When the petitioner transferred the resident from the bed to the wheelchair by herself she acted contrary to the policies and standards of the facility. That transfer needed to be done by two people. No harm was suffered as a result of that divergence from the facility requirements; the Department is not basing its action on that mistake. The petitioner should also have put a gait belt on the resident before transferring her to the wheelchair. Again the department is not complaining of that action. However, these mistakes led to the tragic mistake that did lead to serious injury to the resident. If the resident had a gait belt on when petitioner was attempting to help her from the wheelchair to the commode the accident might have been prevented. One cannot say for sure that the gait belt would have prevented the accident but it would have given petitioner something substantial to grab when she saw the resident begin to fall. That is the reason for the gait belt requirement.

Petitioner initially told the investigators that she had put a gait belt on the resident before the fall. In fact, she put a gait belt on the resident after the fall. Petitioner knew that she should have put a gait belt on the resident before the transfer to the commode. She admitted that in her March 6, 2010 statement, (Ex. 4) Also, her initial statement that she had put the gait belt on the resident before the accident shows that she was covering up that which she knew to be wrong. She did not admit the failure until the investigation had turned up the truth.

Petitioner's failure to use the gait belt against the facility's clearly established policies and standards was neglect as defined above. It was an intentional omission contrary to the facility's policies and procedures that could reasonably be expected to cause injury to the resident. In fact it played a role in causing serious injury to the resident. As a result of the fractured kneecap and its aftermath her leg eventually had to be amputated above the knee. There is also considerable evidence that the incident caused emotional damage to the resident. Further, it was not an act of mere inefficiency, unsatisfactory conduct, or failure in good performance as the result of inability, incapacity, inadvertency, or ordinary negligence in an isolated instance. It also was not a good faith error in judgment or discretion. This was not an area in which petitioner was allowed to use discretion.

CONCLUSIONS OF LAW

DHS may place a finding of neglect in the Caregiver Misconduct Registry in petitioner's name.

NOW, THEREFORE, it is ORDERED

That the petition for review is dismissed.

REQUEST FOR A REHEARING

This is a final hearing decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. To ask for a new hearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875.

Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

Your request for a new hearing must be received no later than 20 days after the date of this decision. Late requests cannot be granted. The process for asking for a new hearing is in Wisconsin Statutes § 227.49. A copy of the statutes can found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. Appeals must be served on the Office of the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 650, Madison, Wisconsin, 53703.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to circuit court is in Wisconsin Statutes §§ 227.52 and 227.53.

Given under my hand at the City of
Madison, Wisconsin, this _____ day
of _____, 2010.

Thomas H. Bround
Administrative Law Judge
Division of Hearings and Appeals