COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss. **Division of Administrative Law Appeals**

Department of Public Health,

Petitioner

v. Docket No. PHNA-15-398

Margaret Mbugua,

Respondent

Appearance for Petitioner:

Joel Buenaventura, Esq.
Department of Public Health
250 Washington Street, 2nd Floor
Boston, MA 02108

Appearance for Respondent:

Jeffrey W. Brids, Esq.
1212 Hancock Street
Quincy, MA 02169

Administrative Magistrate:

James P. Rooney, Esq.

SUMMARY

Respondent's name shall not be placed in the nurse aide registry because the evidence does not support a finding that she abused a nursing home resident by willfully gripping her arm so tightly as to cause pain or by retaliating against the resident by throwing pillows at her.

DECISION

On June 4, 2015, the Department of Public Health issued a determination that an allegation of abuse of a resident of the Royal Norwell Nursing Home against certified nurse aide

Margaret Mbugua was valid. Ms. Mbugua filed a timely request for hearing to contest the determination.

I held a hearing on July 15, 2016. I admitted into evidence twelve exhibits (ten from the Department and two from Ms. Mbugua) and made a digital recording of the hearing. Three witnesses who worked at the Royal Norwell Nursing Home at the time of the incident testified for the Department: Derrick LeBlanc, the facility administrator; Sidney Parker, the Director of Nurses; and Tamara Thompson, a licensed practical nurse. Kathleen Walsh, a licensed social worker, who was the Department's surveyor, testified as well. Ms. Mbugua testified. She also presented testimony from Eugene Daly, a registered nurse who worked at the facility at the time of the incident. Both parties made oral closing arguments.

FINDINGS OF FACT

Based on the testimony and exhibits admitted at the hearing and reasonable inferences from them, I make the following findings of fact:

1. Margaret Mbugua has been a certified nurse aide for 14 years. In early 2015, she was working full-time at a nursing home operated by Wingate Healthcare. In January 2015, she began a second job working per diem at Royal Norwell Nursing and Rehabilitation for approximately 16 to 24 hours per week. (Mbugua testimony.) She was trained in the facility's abuse policy. (Parker testimony.)

2. In the early morning hours of March 13, 2015, Ms. Mbugua was assigned to work in Royal Norwell's east wing. Tamara Thompson was the nurse assigned to the north wing; Eugene Daly was the nurse assigned to the south wing. (Mbugua, Thompson, and Daly testimony.)

3. At around 2:30 a.m., Ms. Mbugua went to the north wing to relieve a nurse aide who was on her break. Ms. Mbugua had worked on that wing with Ms. Thompson three to four times without incident. (Mbugua and Thompson testimony.)

4. One of the residents had been sitting in a chair by the nurses' station. This resident was an alert and oriented woman in her 50s with end-stage lung cancer who was receiving palliative care at the facility. She was five feet tall and frail, weighing under 80 pounds, and had fallen frequently. She could walk, but was unsteady and needed assistance. One person could assist her, preferably with a gait belt. Once in bed, the resident could sit up and lie down by herself. (Thompson, Parker, and Daly testimony.)

5. The resident had been at the nurses' station, as was often the case at night, because she was having difficulty sleeping. (Parker and Daly testimony.) After Ms. Mbugua came onto the wing, the resident asked Ms. Thompson if someone could walk her to her room. Ms. Thompson asked Ms. Mbugua to do so. Ms. Mbugua was unfamiliar with the resident, did not know her care plan, and did not know which room was hers. When Ms. Mbugua did not move toward the resident immediately, Ms. Thompson thought she might have the mistaken impression that the resident could come to her, so she told Ms. Mbugua, "No, she needs you to help her." Ms. Thompson also told the resident to be careful not to fall out of bed. (Mbugua and Thompson testimony.)

6. Ms. Mbugua put her right hand in the resident's left hand and the two started walking toward the resident's room. Ms. Mbugua did not use a gait belt because she had accidentally left her belt in the facility's east wing. In order to get to the resident's room, Ms. Mbugua and the resident had to walk by the nurses' station for 15 feet, then turn a corner and proceed another 30 feet to the end of a corridor. Ms. Thompson was able to observe them for the first 15 feet. She

thought Ms. Mbugua was using an appropriate technique to walk the resident and was not walking too fast. (Mbugua and Thompson testimony.)

7. As Ms. Mbugua and the resident were walking down the corridor to the resident's room, Ms. Mbugua sensed that the resident was wobbling. To prevent the resident from falling, Ms. Mbugua placed her right hand on the resident's back and with her left hand held firmly onto the resident's left wrist or forearm. (Mbugua testimony.) As they approached the resident's room, the resident complained that Ms. Mbugua was walking too fast. Ms. Mbugua then slowed down. (DPH Exs. 6 and 8.)

8. When they reached the resident's room, the resident sat down on the edge of her bed. She then told Ms. Mbugua that she had left her two pillows at the nurses' station and asked Ms. Mbugua to retrieve them. Ms. Mbugua went back to the nurses' station to do so. On her return, she found the resident standing by the bed. She tossed the pillows onto the bed and firmly told the resident to go to bed. The resident then sat down on the bed. (Mbugua testimony; DPH Ex. 1.)

9. Ms. Mbugua had found the manner in which Ms. Thompson had ordered her to assist the resident to be unduly harsh, and once she had walked the resident to her room, told Ms. Thompson not to speak to her in that manner again. (Thompson and Mbugua testimony.) A few minutes after the resident was settled in her room, Ms. Thompson went to the room to check on the resident. She found the resident sitting on the side of her bed crying and holding her wrist. Ms. Thompson examined her wrist and did not find any signs of injury. The resident told Ms. Thompson that Ms. Mbugua had treated her roughly and hurt her wrist. The resident and her roommate told Ms. Thompson that Ms. Mbugua had thrown pillows in the direction of the resident, although the pillows did not hit her. (Thompson testimony; DPH Ex. 7.)

10. Ms. Thompson told Ms. Mbugua to leave the unit because she had been rough with a resident. She then placed a call to the Director of Nurses, Sidney Parker, to report a case of suspected abuse. She prepared a written statement before she left the facility at 7:00 a.m. (Thompson and Daly testimony; DPH Ex. 7.)

11. After Ms. Mbugua left the north wing, she went to the south wing to speak to nurse Eugene Daly. Mr. Daly was familiar with the resident and knew that she was usually up at night. He decided to check on her condition, and so between 3:30 and 4:00 a.m., he went to the resident's room and asked her if she was okay. She told him that she was, that she was in no pain, but that the nurse had told her she had been roughed up. He checked on her again the next day and did not see any bruises on her arm. (Daly testimony; Mbugua Ex. 2.)

12. Ms. Parker arrived at Royal Norwell at 9:00 a.m. She and the administrator, Derrick LeBlanc, interviewed the resident, the resident's roommate, Ms. Thompson, and Ms. Mbugua. The resident told them that when Ms. Mbugua "grabbed her arm it was not gentle, it was rough and started walking fast." The resident was unable to state whether Ms. Mbugua had hurt her; she had no arm pain at the time of the interview. She acknowledged that the nurse aide had slowed down after the resident had complained about being walked too fast. The resident's roommate, who was recuperating at Royal Norwell following surgery and was also alert and oriented, thought that the pillows Ms. Mbugua had thrown had grazed the resident's head; the resident denied being hit by a pillow. Ms. Mbugua denied walking the resident too fast, saying she was new to the floor and did not know the way to the resident's room. She admitted telling the resident not to get up out of bed and saying she did so because the resident was a fall risk. (Parker and LeBlanc testimony; DPH Ex. 6.)

13. A few hours later, social worker Kate Whyte interviewed the resident and her roommate. The resident told Ms. Whyte that when she had decided to go back to her room:

> the aide was asked to help her back by the nurse. She stated the CNA grabbed her by the arm and started walking quickly. She . . . asked her to slow down which the CNA did. When she got to her room, she realized that she forgot her pillows and politely asked the CNA to go back to get them. She stated the CNA sighed loudly (as she had when the nurse originally asked her to walk [the] resident back). She reported the CNA came back and was standing at her roommate's bed (closest to the door) and threw the pillows onto her bed and told her to stay in bed. [The] resident reported she let the nurse know and stated she feels safe and doesn't feel nervous about the CNA. She stated several times that the CNA was rude and did not treat her as she should.

(DPH Ex. 8.)

14. The resident's roommate told Ms. Whyte that she heard the resident tell the nurse aide not to walk so fast. She also stated that the aide had been angered by the request to retrieve pillows, and had been "rough" in an unspecified way with the resident. (DPH Ex. 9.).

15. Three weeks later, Department surveyor Kathleen Walsh interviewed Ms. Thompson, the resident, the resident's roommate, and Ms. Mbugua. The resident told Ms. Walsh that Ms. Mbugau had grabbed her forearm and maintained a "hard grip" as they walked down the hallway. The resident, her roommate, and Ms. Thompson concurred that the resident had cried after Ms. Mbugua had walked her to her room. (Walsh testimony; DPH Ex. 1.)

16. Ms. Walsh concluded that the resident had "suffered physical pain on her arm and mental anguish after receiving care" from Ms. Mbugua. She recommended that the complaint be determined to be valid. (DPH Ex. 1.) She came to this conclusion because the resident, her roommate, and Ms. Thompson all told her the resident was crying after she received care from Ms. Mbugua. (Walsh testimony.)

17. During the investigation of the events of March 13, 2015, neither the nursing home nor the Department interviewed nurse Daly. (Daly testimony.)

18. Royal Norwell administrator LeBlanc was unable to determine whether abuse had occurred. He allowed Ms. Mbugua to return to work. Thereafter, Ms. Mbugua was occasionally assigned to the north wing and took care of the resident without incident. The facility stopped calling her for per diem work after another resident complained that Ms. Mbugua had started care without introducing herself. (LeBlanc, Mbugua, and Parker testimony.)

19. On June 4, 2015, the Department mailed a notice to Ms. Mbugua that it had found the allegations listed in Ms. Walsh's report to be valid and as a consequence was going to list her on the Nurse Aide Registry. (DPH Ex. 2.) Ms. Mbugua timely appealed. (DPH Ex. 3.)

20. Both the resident and her roommate died later in 2015. (Parker testimony.)

DISCUSSION

The Department of Public Health enforces rules barring certified nurse aides from abusing, neglecting, mistreating or misappropriating the property of residents of nursing homes. *See* 105 C.M.R. § 155.000 *et. seq*. Once a finding of abuse, neglect, mistreatment, or misappropriation is finalized, the Department must, under state and federal law, list the finding in the Nurse Aide Registry. *See* M.G.L. c. 11, § 72J, and 42 U.S.C. § 1396r(e)(2). When that happens, no Massachusetts home health agency or long-term care facility may employ the person against whom such a finding is made.

The Department charged Margaret Mbugua with abuse, based on the report of its investigator Kathleen Walsh. The report is not entirely clear as to which of Ms. Mbugua's actions constituted abuse in the Department's opinion. Department counsel clarified this at the hearing. He maintained that Ms. Mbugua abused a nursing home resident by causing her physical pain and mental anguish by gripping her arm too hard while she walked the resident to her room, and by throwing pillows at her to retaliate for being asked to retrieve the pillows from

the nurses' station. Ms. Mbugua responded that she gripped the resident only as hard as necessary to keep her from falling. She denied throwing pillows at the resident, and denied any intent to retaliate against the resident.

Department regulations define abuse as the "willful infliction of injury . . . or punishment with resulting physical harm, pain, or mental anguish." 105 C.M.R. § 155.003. The regulations provide that a nursing home resident has been abused if:

> (a) An individual has made or caused physical contact with the patient or resident in question, either through direct bodily contact or through the use of some object or substance; and
>
> (b) The physical contact in question resulted in death, physical injury, pain or psychological harm to the patient or resident in question; and
>
> (c) The physical contact in question cannot be justified under any of the exceptions set forth in 105 CMR 155.003:

Id. Physical contact is not abuse if:

> The physical contact with the patient or resident occurs in the course of carrying out a prescribed form of care, treatment or therapy, and both the type of physical contact involved and the amount of force used are necessary in order to carry out that prescribed form of care, treatment or therapy, provided that the patient or resident has not refused such care, treatment or therapy.

Id. However, "[p]hysical contact with a patient or resident which harms that patient or resident, and which occurs for the purpose of retaliating against that patient or resident, shall constitute abuse." *Id*.

The Department has not demonstrated that Ms. Mbugua abused a resident on March 13, 2015. There is no evidence that the frail resident was physically injured. Nurses Thompson and Daly examined her shortly after she returned to her room, and neither of them saw any bruising. Still, there is ample evidence that the resident felt pain in her forearm or wrist after Ms. Mbugua

walked her to her room.[1] This alone, however, does not establish abuse. The infliction of pain must have been willful. The Department did not show that Ms. Mbugua willfully caused pain to the resident. She had been directed to walk the resident back to her room. She did so initially within the view of the nurse in charge of the wing who was familiar with the resident and how a nurse aide should assist her while walking. Nurse Thompson thought Ms. Mbugua, who initially held the resident's hand, was performing her task appropriately and not walking too fast. Later in the walk, Ms. Mbugua grabbed the resident's wrist or forearm, and it is undoubtedly this that caused the resident's subsequent physical pain. Ms. Mbugua did so because the resident became wobbly. Knowing that the resident was frail and that nurse Thompson was worried about the resident falling, Ms. Mbugua made a sensible decision to try to provide the resident more support while walking.

There is no evidence to suggest that Ms. Mbugua willfully held the resident too tightly. The resident complained as she neared her room that Ms. Mbugua, who had been walking her at an appropriate pace, was now walking her too swiftly. No intent to harm the resident can be inferred from this, as it was just as likely that Ms. Mbugua sped up once she saw the resident's room in order to shorten the time the resident was at risk of falling in the hallway. Notably, the resident was not heard to complain during the walk that Ms. Mbugua was hurting her arm. Whether the resident's arm was hurting then or not, at the very least, Ms. Mbugua was not told

---

1. What caused the resident to cry is less certain. Although nurse Thomson saw the resident crying a few minutes after Ms. Mbugua left her room, it is not clear that she was crying from wrist pain. It could be that Ms. Mbugua, who was not familiar with this resident, gripped her too hard when she was walking her back to her room, and the resident felt immediate pain in her wrist that caused her to cry. There is no evidence, however, that she cried when she was first brought back to her room or during the time it took Ms. Mbugua to retrieve her pillows. The resident later described Ms. Mbugua's interactions with her as rough or rude, and it could be that some other aspect of their interactions, such as Ms. Mbugua firmly telling the resident to get back into bed, was what led her to cry.

by the resident that her arm hurt. She was told she was walking too fast, and, according to the resident, she then slowed down, which demonstrates that she was attempting to provide appropriate care to the resident – not willfully seeking to harm her.

As for the incident with the pillows, the evidence is too equivocal to show any intent by Ms. Mbugua to retaliate against the resident for asking her to return to the nurses' station to retrieve the resident's pillows. The resident and her roommate both thought that Ms. Mbugua, who they otherwise did not know, was made angry by the resident's request. There is some evidence – from Ms. Mbugua herself – that she was angry, but her anger was directed at nurse Thompson for what she perceived to be the harsh way in which she twice directed Ms. Mbugua to walk the resident to her room. Ms. Mbugua went back to the nurse's station, got the pillows, and returned to the resident's room. There are different versions of what happened then, but there is no evidence that Ms. Mbugua hit the resident with the pillows. The resident herself told the director of nurses and the facility administrator that she was not hit. The only person who thought the resident was hit was her roommate. I have no reason to believe the roommate could sense this better than the resident herself. Ms. Mbugua claimed that she did throw the pillows at all. I am not convinced by this either.[2] Rather, what most likely happened is that Ms. Mbugua, who left the resident sitting on the bed while she retrieved the pillows, returned to find the resident standing beside the bed. Fearing she would fall, she quickly tossed the pillows on the bed and firmly told the resident to get back into bed. This would not be abuse or retaliation.

---

2. The record is replete with differing version of events. There are disputes as to whether the roommate was awake when the resident was brought back to her room, whether the roommate could see what was happening, whether nurse Thompson observed Ms. Mbugua while she was in the resident's room, and whether nurse Thompson was present during the later conversation between Ms. Mbugua and nurse Daly. There is also a claim of racial bias on the part of nurse Thompson. I have not made findings on all of the matters in dispute, only those that are necessary to resolving the charge of resident abuse.

Department counsel argued that Ms. Mbugua should be found to have abused the resident because she did not use a gait belt to steady the resident while walking her. The evidence on whether the care plan for the resident required use of a gait belt while walking her is contradictory. Director of Nurses Parker mentioned use of a gait belt in her testimony; nurse Thompson, who had the most experience with the resident and her care plan, did not. Ms. Walsh, in her investigator's report, described the care plan as requiring two people to assist the resident. Whatever the care plan provided, the reason Ms. Mbugua did not consider using a gait belt when walking the resident was not because she was willfully seeking to endanger the resident, but rather because she had inadvertently left her gait belt in the wing to which she was assigned. More significantly, any failure to use a gait belt here would at most have amounted to neglect, not abuse. Because the Department did not charge Ms. Mbugua with neglect, I make no findings concerning this uncharged matter.

Because I find that the evidence fails to show that Margaret Mbugua willfully inflicted injury on a nursing home resident, I conclude that the Department of Public Health has not met its burden of proving that she engaged in resident abuse. Accordingly, I direct that Ms. Mbugua's name not be placed in the Nurse Aide Registry as the Department proposed.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

_____

James P. Rooney
First Administrative Magistrate

Dated: September 7, 2016