2012 WL 10129913 (Ark.Cir.) (Trial Motion, Memorandum and Affidavit)
Circuit Court of Arkansas.
Pulaski County

Maria DUBOSE,

v.

DIVISON OF MEDICAL SERVICES, et al.

No. CV2012000296.
June 20, 2012.

Petitioner's Brief

Petitioner Maria Dubose, Sanford Law Firm, PLLC, One Financial Center, 650 S Shackleford, Ste 400, Little Rock, AR 72211 Phone:, (501) 221-0088, Fax: (888) 787-2040, Josh Sanford, Ark. Bar No. 2001037, josh@sanfordlawfirm.com.

COMES NOW Petitioner Maria DuBose, by and through her attorney Josh Sanford of Sanford Law Firm, PLLC, and for her Brief in support of her Petition against Respondents Division of Medical Services and Office of Long Term Care does allege and state as follows:

I. INTRODUCTION

On October 11, 2010, the DHS Office of Long Term Care (OLTC) made a finding of long-term care resident **neglect** against Petitioner Maria DuBose pursuant to Ark. Code Ann. § 12-12-1703(15)(B)(i) and (iii). This finding was affirmed by the DHS Office of Appeals and Hearings (OAH), which has resulted in the inability of Petitioner to practice her chosen profession of nursing in the State of Arkansas. *See Maria Dubose v. Division of Medical Services Office of Long Term Care*, Department of Human Services Case No. 20105768, Final Order dated December 7, 2011, attached hereto as Exhibit A and incorporated herein (hereinafter "Final Order"). Petitioner asserts that her substantial rights were prejudiced by the decision of the OAH because the findings, inferences, conclusions, and/or decisions of the OAH are not supported by substantial evidence of record. Ark. Code Ann. § 25-15-212(h)(5).

Specifically, the record in this case does not even remotely support a finding that Petitioner negligently failed to provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision, or medical services to an endangered or impaired person, or that Petitioner negligently failed to carry out a prescribed treatment plan. Ark. Code Ann. § 12-12-1703(15)(B)(i) and (iii). A true and correct copy of the record is attached hereto as Exhibit B, and is incorporated herein (hereinafter the "record"). Indeed, the evidence in the record does not support a finding of negligence on the part of Petitioner in any manner whatsoever. There is no evidence that Petitioner was aware or should have been aware that the resident was a fall risk; no evidence that Petitioner was "in-serviced" (i.e., informed), that the resident was a fall risk; and no evidence that a review of the care plan for the resident would have revealed the resident's status as a fall risk at the time of the incident at issue. Further, the Findings of Fact upon which the OAH based its decision are not based exclusively on the evidence and matters officially noted. Ark. Code Ann. § 25-15-208(6). Therefore, the finding of **neglect** against Petitioner must be reversed.

II. FACTUAL BACKGROUND

On May 22, 2010, Petitioner was working as Certified Nurse's Assistant (CNA) at the Beebe Retirement Center in Beebe, Arkansas. See Record ("R") 6, 11. Just prior to 8:45 in the evening, Petitioner and another staff member of the Beebe Retirement

Center transferred an **elderly** resident (hereinafter "the resident") to the toilet. R 6. After the other staff member left the bathroom, Petitioner noticed that the resident needed a skin cream, and left the bathroom in order to retrieve the skin cream, leaving the resident unattended. R 6, 11. While Petitioner was out of the bathroom, the resident fell off of the toilet, but received no injuries. R 6, 11; Transcript ("T") Page 5, Lines 19-29 (hereinafter represented in the following format: 5:19-29). On May 25, 2010, Brenda Chapman, Administrator for Beebe Retirement Center, completed a Facility Investigation Report for Resident Abuse, **Neglect**, Misappropriation of Property & Exploitation of Residents in Long Term Care Facilities (hereinafter "Facility Investigation"). R 5. In Petitioner's Statement related to the Facility Investigation dated May 23, 2010, Petitioner admitted that she stepped out of the bathroom to get the skin cream and upon returning to the bathroom, saw the resident on the floor. R 11.

The result of the May 22, 2010, fall incident (hereinafter "the incident" or "the fall incident") was an incorrect finding of long-term care resident **neglect** against Petitioner pursuant to Ark. Code Ann. § 12-12-1703(15)(B)(i) and (iii), which was affirmed by the OAH following a hearing on March 31, 2011. Specifically, the OAH erroneously found that the resident was "care planned' to not be left along in the bathroom" and that "Petitioner's [sic] was trained to check care plans daily and had been in serviced on 5/10/10 that the resident was not to be left alone in the bathroom." Exhibit A, Final Order, Page 3. Based on these findings, the OAH affirmed the incorrect finding of **neglect** against Petitioner. It is from this Final Order that Petitioner has appealed.

III. STANDARD OF REVIEW

In reviewing administrative decisions, appellate courts will uphold the decisions as long as they are "supported by substantial evidence and are not arbitrary, capricious, or characterized by an abuse of discretion." Batiste v. Arkansas Department of Human Services, 204 S.W.3d 521, 525 (Ark. 2005). Substantial evidence is defined as "valid, legal, and persuasive evidence that a reasonable mind might accept as adequate to support a conclusion, and force the mind to pass beyond conjecture." Ark. Dept. Human Svcs. V. Haen, 100 S.W.3d 740, 741, 81 Ark. App. 171 (2003). The challenging party has the burden of proving an absence of substantial evidence, Id. To establish an absence of substantial evidence to support the decision the challenging party must demonstrate that the proof before the administrative tribunal was so nearly undisputed that fair-minded persons could not reach its conclusions, Id at 741-742; Wright v. Arkansas State Plant Board, 842 S.W.2d 42, 45 (Ark. 1992). The entire record must be reviewed in making that determination, Id. at 742.

In reviewing the record, appellate courts give the evidence its strongest probative force in favor of the administrative agency. Batiste, 204 S.W.3d at 525. The question is not whether the testimony would have supported a contrary finding, but whether it supports the finding that was made, Id. To be invalid as arbitrary or capricious, an agency's decision must lack a rational basis or rely on a finding of fact based on an erroneous view of the law. Id. As true for any other fact-finder, it is the prerogative of the agency to believe or disbelieve any witness and to decide what weight to accord the evidence. Id. Finally, the Court may not accept the agency's post hoc rationalizations for its actions, but rather agency action must be upheld on a basis articulated by the agency itself. Haen, 100 S.W.3d at 744.

IV. ARGUMENT

There is no dispute but that the OAH decision to uphold the finding of **neglect** against Petitioner has affected Petitioner's ability to practice her chosen profession, thus affecting her substantial rights. Pursuant to Ark. Code Ann. § 25-15-212(h), Petitioner's substantial rights have been prejudiced because the findings, inferences, conclusions, and decisions of the OAH are not supported by substantial evidence of record. A finding of "**neglect**" under Ark. Code Ann. § 12-12-1703(15)(B)(i) and (iii) requires proof of negligence. Negligence requires a showing that a duty was breached. Pilcher v. Suttle Equipment Co., 223 S.W.3d 789, 793 (Ark. 2006). There was no evidence of negligence or a breach of duty on the part of Petitioner in leaving the resident unattended in the bathroom because there was no evidence that Petitioner knew or should have known that the resident was a fall risk.

Petitioner would only have known that the resident was a fall risk if she had received the information via "inservice" provided by the Beebe Retirement Center or via the care plan located in the ADL books available to the nursing staff at the Beebe Retirement Center. There is simply no evidence in the record that Petitioner was inserviced prior to the resident's fall incident or that the resident's status as a fall risk was noted in the ADL book prior to the resident's fall incident; the testimony and evidence presented provides no basis, without resorting to speculation or conjecture, for the findings of the OAH that the resident was "care planned" to not be left alone in the bathroom or that Petitioner was inserviced prior to the fall incident on the subject of not leaving the resident alone in the bathroom. Exhibit A, Final Order, Page 3. Without a finding that Petitioner was in fact, explicitly inserviced prior to the fall incident or that the resident was care planned as a fall risk prior to the fall incident, there can be no accurate finding of **neglect**; therefore, the finding of **neglect** against Petitioner is not supported by substantial evidence of record and must be reversed.

A. The record contains no evidence that Petitioner was inserviced prior to the resident's fall incident.

Although OLTC has taken the position that Petitioner was inserviced on May 10, 2010, twelve days prior to the fall incident, and the OAH found that Petitioner was so inserviced, the record contains no evidence that Petitioner was in-serviced prior to the resident's fall. Other than through the ADL books, more fully discussed in the next subsection, without having been in-serviced Petitioner could not have known that the resident was a fall risk; therefore the record cannot support a finding of negligence on Petitioner's part in leaving the resident alone in the bathroom, and the finding of **neglect** must be reversed.

The documentation provided by the Beebe Retirement Center relating to the resident included an Inservice Education Report. R 6. The Inservice Education Report was dated May 10, 2010, and May 23, 2010. This second date was after the May 22, 2010, fall incident, and the first date followed a fall by the patient on May 6, 2010. R 16, 18; T 9:37-45. The Inservice Education Report was signed by Petitioner, but was dated May 23, 2010, indicating that Petitioner received the in-service on May 23, 2010, the day after the fall incident. R 16. This is consistent with Petitioner's assertion that she did not get the in-service until May 23, 2010, the day after the fall, and that she had no knowledge that the resident was not supposed to be left unattended. R 1; T 31:23-35.

In addition, the "Findings and Actions Taken" section of the Facility Investigation Report mentions that "Inservice to staff was started 5/23/2010 about to not leave this resident alone in the bathroom," but makes no mention of any inservice on May 10, 2010, which would be incredibly relevant to an investigation of the fall and would have been difficult to miss since the Inservice Education Report contained both dates in very large lettering. R8, 16. Further, the "Standard Care Plan for Fall Prevention" notes a CNA inservice on May 6, 2010, and May 24, 2010, neither of which is consistent with the May 10, 2010, and May 23, 2010, inservice dates contained on the Inservice Education Report. R 16, 18. Further, the May 6 entry states "CNA inservice - Do Not leave alone in BR" while the May 24 entry states "All CNAs inserviced; Do not leave alone in bathroom." R 18 (emphasis added). The clear import is that not all CNAs were inserviced on May 6 (which Petitioner can only assume was intended to refer to the May 10 inservice). Even more telling is that the "Date Care Plan Initiated" noted on the "Standard Care Plan for Fall Prevention" is May 24, 2010, two days after the fall at issue. R 18. In short, all of the documentation provided by the Beebe Retirement Center indicates that Petitioner was not inserviced until at least May 23, 2010.

Rather than relying on the documentation contained in the record, which clearly demonstrates that Petitioner was inserviced on May 23, 2010, the OAH relied upon supposed witness testimony "that [Petitioner] had been in serviced on 5/10/10, and that it was also documented in the resident's care plan on 5/6/10." Exhibit A, Final Order, Page 1. While the care plan is discussed below, the OAH's reliance on witness testimony that Petitioner was inserviced on May 10, 2010, was in error. Not a single witness actually testified that they saw or otherwise knew Petitioner had been inserviced on May 10, 2010, and the documentary evidence bears out that she was not so inserviced. Petitioner's signature next to the May 23rd inservicing is dispositive on this issue.

Brenda Chapman, Administrator for the Beebe Retirement Center, stated that the Inservice Education Report was presented by LPN Heather Barnett on May 10, 2010. T 4:27-31, 7:1-29; R 16. Ms. Chapman then stated that another Inservice Education

Report relating to leaving **elders** unattended was presented on May 23, 2010, by LPN Kimberly Washam. T 8:14 - 28; R 17. Ms. Chapman does not indicate that she was present on May 10 or May 23 when either of the Inservice Education Reports were presented or that she knew Petitioner was present on either of those particular dates. Further, Ms. Chapman's testimony clearly indicates that she could not be sure that any given employee was present on the date any particular inservice was given; Ms. Chapman states that she could not say with "100 percent" certainty that Petitioner was present at the Beebe Retirement Center on May 23, 2010, when the inservice was given, but could only assume that Petitioner was present by her signature on the Inservice Education Report. T 9:7-10. In other words, Ms. Chapman has no knowledge of whether Petitioner was present either on May 10 or May 23, and cannot (and in fact does not) dispute that Petitioner did not receive the Inservice Education Report until May 23, 2010, the date indicated on the Inservice Education Report itself. R 16. Accordingly, the sole significance of Ms. Chapman's testimony is to confirm that Petitioner was likely not present for the May 10th inservicing, since Petitioner's signature is not found in the records from that day.

The next witness, Ms. Bobby lvie, Director of Nurses for Beebe Retirement Center, acknowledged the May 23, 2010, date by Petitioner's name on the Inservice Education Report relating to the resident's fall risk, but stated that she did not know why the date was there. T 14:9-15; 17:45-56; 18:1-5; R 16. Notably, Ms. Ivie does not make any attempt to dispute that Petitioner received the Inservice Education Report on May 23, 2010, which is the date noted. Neither does Ms. Ivie indicate that she was present at the presentation of the Inservice Education Report on either May 10 or May 23, 2010, therefore Ms. Ivie has no actual knowledge regarding whether Petitioner was present on either of those dates. Ms. Bobby Ivie's testimony was a waste of time as she had no personal knowledge of any relevant facts.

Finally, Ms. Heather Barnett, LPN with Beebe Retirement Center, testified that she was responsible for presenting the Inservice Education Report regarding the status of the resident at issue as a fall risk on May 10, 2010, and May 23, 2010. T 24:13-24; R 16. Although Ms. Barnett was the individual presenting the Inservice Education Report, Ms. Barnett never stated that Petitioner received the Inservice Education Report prior to May 23, 2010. Ms. Barnett's testimony is no more helpful than was Ms. Ivie's.

In sum, Petitioner's name on the Inservice Education Report relating to the resident at issue included the date of May 23, and Petitioner herself testified that she did not receive the Inservice Education Report until May 23, 2010. Not one witness actually disputed this testimony. Not one witness testified that Petitioner received the Inservice Education Report on May 10, 2010, or at any time prior to May 23, 2010; this includes Ms. Barnett, the LPN who was actually responsible for presenting the Inservice Education Report to Petitioner. Petitioner asserts she did not receive the Inservice Education Report until May 23, 2010, and no evidence or testimony was ever presented to dispute this assertion, and her dated signature bears out her assertion.

Because no witness actually stated Petitioner was inserviced on May 10, 2010, or had any actual knowledge as to whether Petitioner was inserviced on May 10, 2010, and because the only documentary evidence, being the Inservice Education Report, indicates that Petitioner was inserviced on May 23, 2010, the Finding of Fact by the OAH that "witnesses testified that [Petitioner] had been in serviced on 5/10/10" is not based exclusively on the evidence, but rather requires the OAH to resort to conjecture and speculation. Because there was no evidence that Petitioner was aware or should have been aware that the resident was a fall risk, the finding of **neglect** against Petitioner must be reversed.

B. The record contained no evidence that a review of the ADL books would have revealed that the resident at issue was a fall risk prior to the resident's fall.

As set forth above, Petitioner was not made aware of the fall risk through any inservice received prior to the fall date, so the only source of knowledge of the resident's fall risk must have been obtained through the ADL books. The record contained no evidence that a review of the ADL books would have revealed that the resident at issue was a fall risk prior to the resident's fall; therefore, the record cannot support a finding of negligence on Petitioner's part in leaving the resident alone in the bathroom, and the finding of **neglect** must be reversed.

The ADL book documentation provided by the Beebe Retirement Center relating to the resident does not establish that Petitioner could have known that the resident was a fall risk prior to the resident's fall. According to witness testimony, only the resident's care plan and the "Standard Care Plan for Fall Prevention" were included in the ADL books which were available to all CNA's. R 15, 18; T 6:19-33; 9:14-22. Not only do these two documents not establish that the resident's fall risk was noted in the ADL books prior to the incident at issue, but they conclusively establish that the care plan regarding the resident's fall risk was not initiated until May 24, 2010, two days after the fall incident.

The first document referenced was generically referred to as the "resident's care plan" and was dated April 14, 2010. R 15; T 6:19-33. This document included a sticker that stated "High Risk Falls Do Not Leave in BR Alone." R 15. The resident did not become a known fall risk until she fell on May 6, 2010, so the sticker would not have been placed on the care plan on April 14, 2010. R 15. Because no date other than April 14, 2010, is noted on the resident's care plan, it is impossible to know solely by looking at the document when the sticker was attached, therefore evidence of the date that the sticker was placed on the resident's care plan must come from another source. R 15.

The only evidence of when the sticker was placed on the care plan came from Beebe Retirement Center, but this evidence was inconsistent, with one witness stating it was placed on the care plan on May 10, 2010, and the other stating it was placed on the care plan on May 6, 2010. T 7:3-5; 16:37-46, 17:1-11; 24:1-11. This is hardly sufficient or persuasive evidence establishing that the sticker was placed on the document prior to the incident at issue, especially in the face of Petitioner's firm assertion that the sticker was not on the document prior to the incident. T 31:23-25.

The other document contained in the ADL books was the "Standard Care Plan for Fall Prevention." R 18. This document absolutely and conclusively establishes that ADL books did not reference the resident's fall risk prior to the incident at issue. When questioned about the "Standard Care Plan for *Fall Prevention,"* Ms. Chapman stated "That's her care plan." T 9:14-18. Despite the resident's previous fall on *May 6, 2010,* the "Standard Care Plan for Fall Prevention" states that the "Date Care Plan Initiated" was May 24, 2010. R 18 (emphasis added). This date is two days after the incident at issue. For the OAH to accept the position of the OLTC and the Beebe Retirement Center that documentation of a care plan initiated on May 24, 2010, was available to Petitioner in the ADL books on or prior to May 22, 2010, is absurd and confirms the credibility of Petitioner's assertion that the ADL books made no reference to the resident's fall risk. It also confirms the incredibility of the OLTC's position that the fall risk reference was made on either April 14th, May 6th or May 10th—who knows which?

Further, the initiation date for the "Standard Care Plan for Fall Prevention" of May 24, 2010, contradicts witness statements that the sticker noting the resident's fall risk was place in the resident's care plan prior to May 22, 2010. It makes no sense to suggest that a "Standard Care Plan for Fall Prevention," which is a specific document relating to fall prevention for a resident, would be initiated after updating the resident's general care plan to note the resident's fall risk. It seems a bizarre stretch to suggest that the resident's general care plan was updated with a sticker noting the resident's fall risk more than two weeks prior to initiating the "Standard Care Plan for Fall Prevention." The only date available relating to a care plan addressing the resident's status as a fall risk is the "Standard Care Plan for Fall Prevention" initiation date of May 24, 2010, yet the OAH completely ignored this date in favor of contradictory evidence relating to an otherwise unknown date that a sticker was attached to the resident's general care plan.

In short, in relying on the ADL books as the source of Petitioner's alleged knowledge of the resident's fall risk, OLTC and the OAH reference only two documents, one of which specifically states that the "Standard Care Plan for Fall Prevention" was initiated two days after the incident, and the other which contains no date other than April 14, 2010, which is approximately three weeks before the resident actually became a fall risk. These documents simply provide no competent or credible evidence that the fall risk was noted in the ADL books prior to the incident. Further, the testimony from Beebe Retirement Center employees indicating that the sticker noting the resident's fall risk was placed on the care plan sheet prior to the incident was inconsistent. While the OAH has great latitude in determining the credibility of witnesses, the OAH's disbelief of Petitioner's firm testimony that the sticker was not in the ADL books prior to the incident based on Beebe Retirement Center's inconsistent testimony regarding the sticker crosses the bounds of that latitude. The OAH's position is in fact ludicrous.

The documents and testimony in the record do not provide any evidence that the ADL books noted the resident's fall risk prior to the incident. If the fall risk was not noted in the ADL books, then Petitioner could not have known of the fall risk by reviewing the ADL books. If Petitioner was not aware of the fall risk, then Petitioner did not breach any duty owed by her to the resident, and the finding of negligence against Petitioner cannot stand.

C. No other evidence or testimony supports a finding that Petitioner had knowledge of the resident's status as a fall risk prior to the fall incident.

No other evidence or testimony supports a finding that Petitioner had knowledge of the resident's status as a fall risk prior to the fall incident. The testimony of the witnesses relating to Petitioner's "knowledge" is vague, provides no information regarding Petitioner's knowledge of the resident's fall risk at the time of the incident, and includes no indication of whether Petitioner's alleged general "knowledge" related to the specific resident at issue or whether Petitioner's "knowledge" related to general practices of leaving residents unattended in the bathroom.

When asked point-blank whether Petitioner knew or should have known that the resident was not to be left alone in the bathroom, Ms. Chapman clearly did not have actual knowledge of what Petitioner knew, but rather responded "In my opinion, yes." T 12:6-10 (emphasis added). When asked whether Petitioner admitted to Ms. Chapman that Petitioner failed "to provide necessary care when she left the resident alone in the bathroom," Ms. Chapman responded, "Yes." T 12:31-38. The "interview" referred to was related to the fall incident and would have been taken after the fall incident, yet Ms. Chapman's response does not in any way indicate what, if anything at all, Petitioner knew prior to the fall incident. Further, while Ms. Chapman states that Petitioner admitted to failing to "provide necessary care" by leaving the resident alone in the bathroom, even if Petitioner made such an admission, this is a general statement that provides absolutely no evidence regarding whether Petitioner actually knew the resident was a fall risk.

Ms. Bobby Ivie stated that she was present when Ms. Chapman interviewed Petitioner after the fall and that Petitioner admitted she knew she was not supposed to leave the resident alone. T 16:6-18. This statement does not indicate whether Petitioner knew she was not supposed to leave the resident unattended prior to the fall or whether Petitioner discovered this information by the May 23, 2010, Inservice Education Report; and in fact the statement does not indicate whether Petitioner was aware that she was not supposed to leave that particular resident unattended or whether Petitioner's knowledge was that it was generally the best practice not to leave any **elders** unattended. To interpret Ms. Ivie's statement that Petitioner "admit[ted] she knew she wasn't supposed to" leave the resident unattended to mean that Petitioner read and received the Inservice Education Report or the ADL book care plan or knew that the resident was a fall risk prior to the fall is unreasonable, would be based on conjecture, and does not comport with the actual statement or any of the other evidence presented in this case.

There is quite simply no clear or competent evidence indicating that Petitioner had any actual knowledge relating to the resident's fall risk. If Petitioner was not aware of the fall risk, then Petitioner did not breach any duty to the resident, and the finding of negligence against Petitioner cannot stand.

D. Summary

Essentially, the only real issue in this case is this: What was Petitioner's knowledge of the resident's fall risk at the time of the resident's fall on May 22, 2012? The OLTC and OAH relied upon, and the evidence only reflects, two possible sources of information concerning the resident's status as a fall risk: 1) the Inservice Education Reports; and 2) the ADL books. As fully discussed above and summarized below, the record does not support a finding that Petitioner received or should have received information from either of these sources prior to the resident's fall on May 22, 2010.
1. Inservice Education Report: The only Inservice Education Report relating to the resident was dated as having been presented on May 10, 2010, and May 23, 2010. R 16.

a. The Inservice Education Report was signed and dated by Petitioner for May 23, 2010-the day after the incident.

b. No witness testified that Petitioner was actually present when the Inservice Education Report was presented on May 10, 2010.

c. No witness testified that they saw or had knowledge of Petitioner inappropriately altering the inservice Education Report.

d. Petitioner testified that she did not receive the Inservice Education Report until May 23, 2010.

e. The "Findings and Actions Taken" section of the Facility Investigation Report completed by Ms. Brenda Chapman following the incident stated "Inservice to staff was started 5/23/2010" but makes no reference to any inservice occurring on May 10, 2010.

2. ADL books: There are only two documents contained in the ADL books, which are a general care plan and the "Standard Care Plan for Fall Prevention." R 15, 18.

a. General care plan. R 15.

i. The general care plan contains only one date: April 14, 2010

ii. The only notation of the resident's fall risk on this document is contained on a sticker which was clearly placed on the document sometime after April 14, 2010, as the resident's first fall was on May 6, 2010.

iii. The testimony from employees of the Beebe Retirement Center regarding the date that the sticker was placed on the document was inconsistent.

iv. Petitioner specifically testified that she reviewed the ADL books and the sticker was not present prior to the incident.

v. Beebe Retirement Center's claim that the sticker was placed on the document prior to May 22, 2010, is highly doubtful since the "Standard Care Plan for Fall Prevention" was not initiated until May 24, 2010.

b. Standard Care Plan for Fall Prevention. R 18

i. The name of this document indicates that it is the fall-specific care plan.

ii. This care plan was not "initiated" until May 24, 2010, two days after the fall incident.

As delineated above, the evidence contained in the record, including all documentation and witness testimony, does not provide any basis for the findings of the OAH that Petitioner was inserviced regarding the resident's fall risk and/or received information from the ADL books that the resident was a fall risk prior to May 22, 2010, the date of the fall incident. In other words, the documents and testimony do not provide any evidence that Petitioner had knowledge that the resident was a fall risk prior to the date of the fall incident. Because Petitioner had no knowledge of the resident's status as a fall risk, the finding of **neglect** against Petitioner was not based on substantial evidence of record.

V. CONCLUSION

The finding of **neglect** pursuant to Ark. Code Ann. § 12-12-1703(15)(B)(i) and (iii) are wholly unsupported by the record in this case, therefore a reversal of the OAH's finding of **neglect** is not only warranted but mandated under Ark. Code Ann. § 25-15-212(h)(5). A finding of **neglect** under Ark. Code Ann. § 12-12-1703(15)(B)(i) and (iii) requires a finding that Petitioner

acted negligently. Petitioner's act of briefly leaving the resident alone in the bathroom could only be considered negligent if Petitioner knew or had reason to know that the resident was a fall risk. In determining whether Petitioner knew or had reason to know that the resident was a fall risk, the OAH relied on the Inservice Education Reports and the ADL books as the source of Petitioner's alleged knowledge.

Neither the Inservice Education Reports nor the ADL books provide any actual evidence that Petitioner received any information that the resident was a fall risk prior to May 22, 2010. Further, no witness testified that Petitioner received the Inservice Education Report relating to the resident prior to May 22, 2010, and other than the conflicting testimony regarding the dates that the sticker noting a fall risk was placed in the general care plan, no evidence existed the ADL books contained a fall risk notation prior to May 22, 2010. Meanwhile, Petitioner definitively stated that she did not receive the Inservice Education Report relating to the resident until May 23, 2010, and the ADL books did not contain a reference to the resident's fall risk as of May 22, 2010. To base a finding of **neglect** against Petitioner on conflicting testimony and evidence regarding the date that a sticker was placed on the general care plan is completely unreasonable.

The evidence presented in this case does not constitute "valid, legal, and persuasive evidence that a reasonable mind might accept as adequate to support [the conclusions reached by the OAH], and force the mind to pass beyond conjecture." Reasonable, fair-minded persons would not review the vague and contradictory evidence in this case and find that Petitioner had knowledge that the resident was a fall risk prior to the date of the fall incident. The findings, inferences, conclusions and decisions of the OAH that Petitioner received the Inservice Education Report regarding the resident, that the ADL books referenced the resident's status as a fall risk, and that Petitioner therefore acted negligently in briefly leaving the resident unattended in the bathroom are completely unsupported by substantial evidence of record as required by Ark. Code Ann. § 25-15-212(h)(5) and not based exclusively on evidence or matters officially noted as required by Ark. Code Ann. § 25-15-208(6). As such, the finding of **neglect** against Petitioner must be reversed.

Respectfully submitted,

PETITIONER MARIA DUBOSE

SANFORD LAW FIRM, PLLC

ONE FINANCIAL CENTER

650 S SHACKLEFORD, STE 400

LITTLE ROCK, AR 72211 PHONE:

(501) 221-0088

FAX: (888) 787-2040

BY: */s/ Josh Sanford*

Josh Sanford

Ark. Bar No. 2001037

josh@sanfordlawfirm.com

End of Document