2011 WL 11663247 (N.M. Dist.) (Trial Motion, Memorandum and Affidavit)
District Court of New Mexico.
Second Judicial
Bernalillo County

Patricia VICTOR, CNA, Petitioner,
v.
NEW MEXICO DEPARTMENT OF HEALTH and Alfredo Vigil, M.D., Secretary of Department of Health, Respondents.

No. D202CV201006209.
May 3, 2011.

Department of Health's Response to Petitioners Rule 1-075 Statement of Review Issues

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NOW COMES the New Mexico Department of Health ("Department" or "DOH"), by and through its attorney Assistant General Counsel Elizabeth Trickey, and for its response to the Petitioner's Rule 1-075 Statement of Review Issues, states as follows:

I. STATEMENT OF THE ISSUES

1. Whether the Hearing Officer's decision to admit the DOH' exhibits into evidence and allow the testimony by the DOH' witnesses in a certified nurse aide hearing was arbitrary, capricious and contrary to law.

2. Whether the petitioner was afforded constitutional due process of law at the CNA hearing on April 16, 2010.

3. Whether the Hearing Officer's recommendation, which was adopted by the Secretary of Health in his final decision ordering that the finding that Petitioner had committed **abuse** at the Albuquerque Heights Healthcare and Rehabilitation facility be placed on the certified nurse aide registry, was based upon substantial evidence.

4. Whether the nurse aide registry rule that requires that the Department's final determination of resident **abuse** be placed on the registry within ten days of that decision, and prior to judicial review, is contrary to law.

5. Whether, upon a final determination, the nurse aide registry rule that precludes removal of a finding of **abuse** from the nurse aide registry is contrary to law.

II. SUMMARY OF PROCEEDINGS

Petitioner was accused of **abusing** four different residents in the hospice unit (Tape (T) 1, Side A, Tape Counter Number (TCN) 389-399) at the Albuquerque Heights Healthcare and Rehabilitation facility (ABQ Heights). Intake Information report, Record on Appeal (hereinafter "RA") 32. The hearing was scheduled for April 16, 2010 in Albuquerque at the offices of Hearing Officer Craig T. Erickson. RA 3.

Upon DOH's motion for a confidentiality order based the medical privacy interests of the nursing home residents that would be referred to during the proceeding, whose privacy DOH is required to protect under federal law (HIPAA), Petitioner stated that she did not want the hearing to begin because she did not have an attorney. RA 73. The DOH attorney objected to the continuance because DOH is required to hold a hearing within 30 days. *Id.* DOH witnesses had travelled to Albuquerque from Santa Fe, and been prevented from performing their usual duties that day. *Id.* There had been no notice that Petitioner desired more time to find an attorney, and it was a real hardship for DOH to continue this hearing to return on another occasion. *Id.*

Petitioner acknowledged that she had received the letter dated March 18, 2010 in which she was informed of the DOH's finding of **abuse** against her, her right to request a hearing and bring an attorney to represent her (RA 5), and had understood that she was entitled to have an attorney represent her at the hearing. RA 73. When asked why she had not brought an attorney, Petitioner said she had tried, and called a lawyer's office, but they did not call her back Id. She said that she had intended tell her side at the hearing, and then call a lawyer if she needed one. *Id.*

The Hearing Officer found that Petitioner had notice of the fact that she could bring an attorney, but chose not to. *Id.* He stated that it was clear that she had intended to go forward but changed her mind at the hearing. *Id.* He rejected her request for a continuance. *Id.*

The first witness to testify was DOH long term care surveyor and investigator Rachel Moorhead Lopez, who was sent to ABQ Heights to investigate the report of **abuse** of nursing home residents. RA 75. As of the date of hearing, Ms. Lopez testified that she had five and a half years experience, was SMQT certified, having passed the national qualification test, and had additional training with DOH. Id. She detailed the results of her investigation in her Complaint Investigation Report, which was admitted as DOH Exhibit 2. RA 36-40; and 82.

Ms. Lopez testified at length regarding her investigation. Hearing Officer's summary of testimony ("Testimony"), RA 75-81. The allegations about Petitioner's conduct, and some of the evidence provided [1] are:

1. Petitioner was observed feeding Resident 1 in the dining area of unit 400, a hospice unit. RA 33, 36 & 76. The resident began to cough and Petitioner continued to feed the resident without pausing. *Id.* RN, Mary Garcia confronted Petitioner about her dangerous conduct which could lead to aspiration of food and perhaps death, and noticed a bruise on the resident's elbow. *Id.* RA 66.
2. Petitioner was observed by Resident 4, in the hospice unit, throwing her roommate Resident 2 into a wheelchair. RA 33, 36, 37, 38, 39 86. Resident 2 had had her leg hanging over the foot rest, and Petitioner kicked it "really hard" to get it on top of the foot rest. RA 33, 36, 37, 77, 79, 86. Resident 2 couldn't speak, nor could she do things on her own. *Id*, and RA 39. Testimony at RA 77, 78, 79. Resident 4 reported that this made her cry for her roommate, and afraid for herself. *Id.* She also complained that Petitioner was "really rough" when she cleaned Resident 4's bottom. *Id.* Petitioner seemed like she didn't want to be there, and was always in a hurry and mad. RA 38, 39, Testimony, at RA 76. The Interdisciplinary Team reported in its progress notes that the resident was "traumatized" by what she had seen the Petitioner do to her roommate. RA 67, Testimony 80-81.

3. Petitioner slapped Resident 3's hand. RA 33, 37, 76, 80. Also, HFL&C incident report signed by RN Gabriel Gonzales, RA 51-52; ABQ Heights' internal investigation report, at RA 54; ABQ Heights internal investigation, Witness Statement of CNA Dennis Trammel RA 59. Testimony at RA 76, 78. The Interdisciplinary Team (IDT) reported in its social progress notes that the resident informed the team of this event as well. RA 68.

4. Resident 4 also complained that her own G-tube was pulled by Petitioner. RA 33; Testimony at RA 76, 78

Ms. Lopez' report and testimony reveal a thorough investigation of the allegations of **abuse**. She interviewed a variety of facility staff including eyewitnesses CNA Dennis Trammel, who saw Petitioner slap Resident 3; R.N. Mary Garcia, who saw the feeding incident; Resident 3, who Petitioner was said to have slapped; and Resident 4 (interviewed through a Navajo translator, CNA

Eula Monte, who was also separately questioned), who complained that she was roughly treated by Petitioner, and witnessed the **abuse** of Resident 2, who could not speak or communicate. RA 36-40, and Testimony 77-79.

CNA Montes reported to Ms. Lopez that she had found Resident 4 upset and crying, and when she asked what was wrong, Resident 4 reported that she had witnessed Petitioner yank Resident 2 out of bed, put her in the chair, and when Resident 2 couldn't put her feet on the wheelchair "pedals," she said that Petitioner kicked her feet hard. Testimony RA 77. She also told Ms. Montes that Petitioner was rough with her, and wiped her bottom too hard and it hurt. Testimony RA 77.

These statements are consistent with what Resident 4 told Ms. Lopez (through her interpreter CNA Montes). Ms. Lopez testified that the two appeared to work well together, and Resident 4 was comfortable disclosing what happened. RA 78. Although Resident 4's medical records indicated that she had problems with both short term and long term memory loss, they also stated that she had no problem with memory recall. RA 78-79. Ms. Lopez stated that Resident 4 was able to tell the Navajo interpreter [2] what she saw, and when she was interviewed by Ms. Lopez, she had no hesitation in describing what she had seen. Testimony, RA 79. What she described was consistent with what she had told CNA Montes two months earlier at the time of the events. *Id.* Ms. Lopez testified that when Resident 4 spoke she was visibly upset: "[t]he tone of her voice was stern, bold, and she was mad about the incident. She appeared to be confident in reporting the incident, two months after it occurred." *Id.*

Ms. Lopez also interviewed Ms. Victor. RA 36, & 39-40; Testimony RA 79-80. Ms. Victor told her that she had heard that "someone was **abusing** the residents." Testimony, RA 80. She said that she thought that ABQ Heights did not like black people, and black people were treated differently. RA 79. Ms. Lopez considered that possibility, but rejected it as improbable that this was why Petitioner was accused and terminated for **abuse**. Testimony at RA 80. Ms. Lopez testified that she had been at ABQ Heights over her years surveying for DOH, and witnessed African American individuals working there, including nurses, several CNAs and other staff. RA 80. They had never complained to Ms. Lopez, and remained employed at the facility from one year to the next. *Id.* She did not get the feeling that the staff had anything against black people. *Id.*

Ms. Lopez also reviewed documentation of the charges, many of which were compiled as the facility's internal investigation of the reported **abuse**, and medical records and interdisciplinary team (IDT) records which provided independent notes of what the residents had reported, and the effect on them. RA 36-38, and 39. These were all identified as documents she had reviewed during her investigation, and were admitted as exhibits at hearing. RA 32-68 (DOH Exhibits 1-12).

Ms. Lopez also reviewed Petitioner's personnel records, which showed that she had been hired at St. Theresa Healthcare on July 8, 2009 and terminated from that facility on July 16, 2009. Petitioner reported that she began working at ABQ Heights on a Sunday about two weeks before she was terminated. Testimony, RA 83. Personnel records disclosed that Petitioner had been trained not to **abuse** residents at the facility. RA 42 & Testimony, RA 77. ABQ Heights' records indicated that she was escorted from the facility on August 6, 2009, and officially terminated on August 10, 2009. RA 38; Testimony, RA 77. The reason stated for termination in those records was "Resident Care (no rehire)". *Id.*

Ms. Lopez testified that based upon her investigation, she believed that Petitioner had committed **abuse**. Ms. Lopez testified that she felt strongly that Resident 4 had witnessed the rough wheelchair transfer and kicking, and was visibly upset by it two months later. RA 80. She felt it was **abuse** both for Resident 2 and Resident 4. RA 78 & 80. She also felt that the male resident who had demonstrated to her the hand slap, which CNA Dennis Trammel also described in his interview and his written statement, evidenced mental and physical **abuse**. RA 78, 80. Likewise she considered the feeding incident involving the coughing Resident 1 **abusive** because it was medically inappropriate, which is one form of **abuse**, because the resident could have aspirated the food. Testimony at RA 80. When she was conducting her investigation, two months after they were observed, she could not see the bruises described in the original report, but it is not medically appropriate to keep feeding someone that is choking. *Id.*

DOH witness Theresa Dalton, Nurse Aide Training and Registry Coordinator, testified that she reviewed Ms. Lopez's investigation, and all the related exhibits admitted at hearing, and concurred with her conclusions. Testimony, RA 82. She felt that there was good evidence of **abuse**, and was comfortable with Ms. Lopez' approach to investigations in general, finding her

to be a reliable surveyor. Testimony, RA 82-83. She stated that she knew that if the finding of **abuse** was upheld, Petitioner's name would be permanently placed on the nurse aide registry, and under the circumstances, she thought that was the correct result. Testimony, RA 83.

Petitioner testified on her own behalf. At the hearing, Petitioner admitted that she had had a long hard day in which she had not had a break, nor any lunch, and she had an altercation with Ms. Garcia, the nurse who was supervising her. Testimony, 84-85. She stated that prior to moving to New Mexico, she worked in Florida, but things did not go well there. Testimony, RA 88. She moved to New Mexico on June 6, 2009, and worked at "Preston Place"[3] for two weeks, then moved over to ABQ Heights. *Id.* She testified that she had been accused by one man of breaking his shoulder at Preston Place, but she denied that she did anything wrong, and she was not charged with **abuse** in that case. *Id.* She categorically denied all of the allegations in this case, and anything related to the described events, and also testified that she believed that every person who had made statements against her had lied. Testimony, RA 83-86.

In his "Report and Recommendation of Hearing Officer," Mr. Erickson concluded:

> ... the evidence comes directly from the residents themselves, from other staff who witnessed the events. Ms. Victor's total denial of anything occurring on the day in question which bears any relationship to the events in question is simply not credible. Her total denial, if true, would mean that there would have to have been a conspiracy involving a number of staff and residents to put together four different stories of **abuse**, for an unknown reason, in order to get her out of the facility. It is highly unlikely that **elderly** residents, who are dying in hospice care, would be motivated to do something like this, or that the staff who work with her could succeed in such a conspiracy. RA 90

On April 28, 2010, the Secretary of Health adopted the Hearing Officer's recommendation and ordered that the findings of **abuse** be placed on the nurse aide registry.

III. ARGUMENT

DOH asserts that at the hearing on April 16, 2010, the evidence of **abuse** was multitudinous, and substantial as a matter of law. **Abuse** is defined as:
any act or failure to act performed intentionally, knowingly or recklessly that causes or is likely to cause harm to a resident, including:

(1) Physical contact that harms or is likely to harm a resident of a health facility.

(2) Inappropriate use of a physical restraint, isolation, or medication that harms or is likely to harm a resident.

(3) Inappropriate use of a physical or chemical restraint, medication, or isolation as punishment or in conflict with a physician's order.

(4) Medically inappropriate conduct that causes or is likely to cause physical harm to a resident.

(5) Medically inappropriate conduct that causes or is likely to cause great psychological harm to a resident.

(6) An unlawful act, a threat or menacing conduct directed toward a resident that results and might reasonably be expected to result in fear or emotional or mental distress to a resident. 16.12.20.7 (A) NMAC, RA 46.

One resident reported that she saw Petitioner throw a helpless woman into a wheelchair and kick her foot very hard to get it onto the wheelchair pedals. RA 33, 36, 37, 38, 39 86; Tl, Side B, TCN 028-039. What she saw made her scared for the resident being kicked and for herself. RA 39; Tl, Side B, TCN 032-036. Testimony at RA 77, 78, 79. It was so upsetting it made her cry. RA 77 & 79; Tl, Side B, TCN 032-036. The Interdisciplinary Team (IDT) reported that this resident seemed traumatized by what she had seen. RA 67. Testimony 80-81. Two months later she still seemed angry and quite sure of what she had seen. Testimony, RA 79.

This event alone would qualify as **abuse** of the resident thrown into the wheelchair and kicked because it is physical contact that is likely to harm the resident, it is medically inappropriate and likely to harm, and could also cause psychological harm because this resident could not communicate and was helpless to let anyone know what was happening to her. As for the witnessing resident, she was clearly in mental anguish about what she had seen. She was traumatized. RA 67, 77, 79. Both DOH witnesses, charged with investigating and preventing **abuse**, reached the same conclusion. RA 78, 82. Moreover Petitioner didn't stop there, she also struck another resident, who reported it, and another CNA saw it. RA 33, 37, 59, 68, 76, 80. **Elderly** people have fragile skin and bones, and slapping is never appropriate. Testimony RA 78. A person who is coughing should not be fed more food, yet Petitioner is reported to have done that with another resident, scolding and saying angrily, “Stop your cough and eat.” RA 37. See also RA 33, 36 & 76. One resident's daughter reported that incident, as well as a nurse on duty. RA 37. Not only is it common sense, it is medically inappropriate conduct that is likely to harm a person. The person could choke and die. In every one of these incidents, Petitioner showed such disregard for the rights and safety of nursing home residents that Department of Health determined that she should never have this sort of power over nursing home residents again. RA 92-93.

A. Standard of review

The party challenging an administrative decision has the burden of showing that it was “arbitrary and capricious, not supported by substantial evidence, outside the scope of the agency's authority, or otherwise inconsistent with law.” *See*, *Albuquerque Bernalillo County Water Authority v. New Mexico Public Regulation Commission and Public Service Commission, et al.* 2010 NMSC 13, 117, 148 N.M. 21, 31; 229 P.3d 494, 504, *quoting*, *N.M. Indus. Energy Consumers v. N.M. Pub. Regulation Comm'n,* 2007 NMSC 53, ¶ 13, 142 N.M. 533, 168 P 3d 105. *Accord*, Rule 1-075 (R) NMRA, “Constitutional review by district court of administrative decisions and orders”. For questions of fact, the reviewing court looks to the whole record to determine whether substantial evidence supports the agency decision. *Id.* at ¶ 18. “Substantial evidence on the record as a whole is evidence demonstrating the reasonableness of the agency's decision, and we neither reweigh the evidence nor replace the fact finder's conclusions with our own.” *Id. quoting*, *De Witt v. Rent-A-Center, Inc.*, 2009 NMSC 32, 112, 146 N.M. 453, 212 P.3d 341.

“A ruling by an administrative agency is arbitrary and capricious if it is unreasonable or without a rational basis, when viewed in light of the whole record.” *Archuleta v. Santa Fe Police Department, et al,* 2005 NMSC 6,117; 137 N.M. 161, 168; 108 P.3d 1019, 1026; *quoting Rio Grande Chapter of the Sierra Club,* 2003 NMSC 5, 117. The reviewing court must be careful not to substitute its judgment for that of the agency when considering whether a decision was arbitrary or capricious. *Id.* Only questions of law are reviewed *de novo,* but the court may take into account the nature of the agency and its power to determine fundamental policy. *Id,* at 118 *citing Morningstar Water Users Ass‘n v. N.M. Public Util. Comm‘n,* 120 N.M. 579, 583, 904 P. 2d 28, 32 (1995). Deference is accorded to an agency's interpretation of its enabling statute and rules.

Overall New Mexico courts will not disturb an agency's findings absent obvious error. “The standard of review courts must follow is a narrow one, and the Court may not substitute its judgment for the agency‘s.” *Copar Pumice Co., Inc. v. Dale Bosworth,* 502 F. Supp. 2d 1200 (N.M. 2007), *citing Citizens to Preserve Overton Park v. Volpe,* 401 U.S. 402, 416 (1971). It must not reweigh the evidence or substitute its judgment for the agency's if the findings are supported by substantial evidence in the record. *Gallegos v. NM State Corrections Department,* 115 N.M. 797; 858 P.2d 1276 (Ct. App 1992). Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. Copar Pumice, supra, at 1209, *citing Doyal v. Barnhart,* 331 F. 3d 758, 760 (10th Cir. 2003). *See also, Leonard v. Payday Professional,* 142 N.M. 605, 2007 NMCA 128, 168 P.3d 177 (Ct. App. 2007) *quoting Tallman v. ABF,* 108 N.M. 124, 129, 767 P.2d 363 (Ct. App. 1988) (“We view ‘all evidence, favorable and unfavorable,...in the light most favorable to the agency's decision”).

B. The Exhibits and Testimony at the Hearing Were Properly Admitted, and Provide Substantial Evidence to Support the Department's Decision.

Petitioner complains that evidence submitted on behalf of the Department consists of hearsay, and therefore not admissible in a court of law. As such she considers its consideration arbitrary and capricious, not providing substantial evidence and contrary to law. Not so. Petitioners argument completely disregards the fact that this was an administrative hearing. The nurse aide hearing rules expressly state: "The Rules of Evidence do not apply, however, evidence shall be admitted if it is the type that a reasonable person would rely on in the conduct of his/her affairs." 16.12.20.16 (C) NMAC. It does not say that the person must be a lawyer, which undoubtedly he or she would have to be to raise a hearsay argument. It merely requires that the evidence be the type that a reasonable person would consider reliable. Constitutional due process does not require that an agency provide all the elements of a judicial proceeding. *Archuleta v. Santa Fe Police Dept, supra,* at ¶32. As is recognized in a multitude of cases, administrative hearings are designed to be less formal, and the technical rule of evidence and procedure frequently do not apply. *Id.*, at 121.

Moreover, if one is to insist on application of formal rules, then it must be noted that this hearsay objection was not raised at the hearing. A general statement that the exhibits and testimony was "a bunch of lies," (RA 81) did not put the DOH or the hearing officer on notice of the form of Petitioners objection so that it could be addressed. *As noted in Oden v. New Mexico Regulation and Licensing Department,* 1996 NMSC 22, 110,121 N.M. 670, 673, 916 P 2d 1337,1340, quoting Poorbaugh v. Mullen, 99 N.M. 11, 17, 653 P.2d 511, 517 (Ct. App.) *cert. denied,* 99 N.M. 47, 653 P.2d 878 (1982) "[o]bjections in general terms are not sufficient to advise the [trial] court of the particular claim of error so that it may be corrected." Objections that are so waived may not be raised in an appeal such as before this Court today. *Id.*

Moreover, much of the evidence, including DOH exhibits 4, 6, 7, 8, 9, 10, 11, and 12, was identified by DOH investigator Ms. Lopez as documents she reviewed at the facility that constitute ABQ Heights own business records which constituted the facility's internal investigation of the **abuse** allegations. Exhibit 8 was identified as the CNA Navajo interpreter's written statement of what Resident 4 had told her which Ms. Lopez reviewed at the facility. (T1, Side A, at TCN 384-388). Exhibit 4 was identified by Ms. Lopez as a disciplinary action record from Petitioner's personnel file which, among other things, reported that residents were complaining that she was rough with them. *Id,* at TCN 490. These are records created and maintained in the ordinary course of business, a recognized exception to hearsay. Rule 11-803 (F), NMRE; RA 77, 80.

Exhibit 3 was identified at hearing as Ms. Lopez' own notes about some of the information she gleaned from Petitioner's personnel file. RA 77. This is also a DOH business record created by Ms. Lopez. There are also the incident reports Ms. Lopez identified as having reviewed during her investigation, which are required by law to be sent to DOH by the facility, and were received by and reviewed by DOH in the ordinary course of its business. RA 32-24; RA 51-55. DOH exhibit 2 (RA 36-40) was identified by Ms. Lopez' as her own report, which documents the extensive investigation she undertook over the course of several days at ABQ Heights. Her investigation included interviews of the facility's residents and staff eyewitnesses of Petitioner's conduct, review of the facilities internal records and investigation report, and witnesses' signed written statements. All of these documents, including the witness statements signed by CNA Dennis Trammel (RA 59), was prepared as part of the facility's internal investigation and presented to Ms. Lopez at the facility. As stated by Ms. Lopez at the hearing, "the male CNA, who witnessed this, from what he was saying, the male resident seemed more agitated." T1, Side A, TCN 604-607. It was a violation of the resident's rights to strike him. *Id.* at TCN 607-615. She believed, based on what the male CNA had said, that Resident 3 had exhibited signs of mental anguish that constituted **abuse** of this resident. T1, Side A, TCN 599-606.

Exhibit 12, which consists of four pages of "Social Work Progress Notes," was identified by Ms. Lopez as the Interdisciplinary team (IDT) meetings notes, also reviewed while she was at the faclity. RA 80. The IDT is responsible for the residents' plan of care "...which includes integrated program activities, therapies and treatments designed to help each resident." 7.9.2.32. (J) NMAC. These not only would be business records under Rule 11-803(F), NMRE, but because Petitioner's conduct in relation to the residents was reported in those notes in order to medically treat the affected residents, it therefore would also qualify as "Statements for purposes of medical diagnosis or treatment," another hearsay exception under Rule 11-803 (C). These clearly

are good evidence of Petitioner's conduct, by which Resident 4 was reported by the IDT as "very traumatized" by what she had witnessed the CNA do to her roommate. RA 67.

Petitioner objects that some of these reports may contain hearsay within hearsay, but reports by residents of **abuse**, where the resident is still responding to the excitement of the incident, have been considered excited utterances, also an exception to hearsay. *Benitez v. DOH,* 2009 UT App 250 (where decision attacked as relying solely on inadmissible hearsay, court ruled that considering the age and condition of the **elderly** victim, she remained under stress of the excitement caused by the triggering event ten days after the occurrence, and was an exception to general rule against hearsay). *See also, Hill v. Pennsylvania DOH,* 711 A.2d 1068 (1998) (in cases where there was no eyewitness other than accused CNA, hearsay statement of resident alleged to be mentally incapacitated ruled an excited utterance by reviewing court, and the finding of **abuse** for striking the resident was upheld). *In Hill, supra,* the court also specifically noted that notwithstanding diminished mental capacity, it is generally presumed that a person is competent to testify. *Id.,* at 1070. The objection, and the burden of proving incompetency falls on the party asserting incompetency. *Id.* No such objection or proof was made against any of the residents whose statements were admitted. Moreover the evidence was overwhelmingly to the contrary. For example, as to Resident 4 (the resident that witnessed her roommate being kicked) Ms. Lopez testified that two months later, this witness seemed very sure, and visibly upset, about what she had seen Petitioner do to her roommate and experienced herself. T1, Side B, at TCN 009- 015; also *Id.*, at TCN 028-048.

Petitioner also complains that no subpoenas were issued to witnesses. She is correct. Neither the parties nor the hearing officer has the power to issue subpoenas in CNA hearings. In general, subpoena power is authorized by statute or rule. See, e.g., Rule 1-045 NMRA. The nurse aide hearing rules do not confer such power. DOH also never calls facility residents as witnesses. The reasons are obvious. DOH is charged with preventing emotional trauma of these generally **elderly** and fragile citizens. Therefore, the idea of calling them to a hearing is unthinkable, particularly in a case such as this where all of the residents **abused** were in a hospice unit at ABQ Heights. It seems likely that they may not even have still been alive as of the time of the hearing.

In short, Petitioner totally disregards all of the documentary evidence and the testimony of the DOH witnesses who described in detail their personal review of the documentary evidence and statements of eyewitnesses at the facility. The investigator personally interviewed all of those witnesses and victims of the **abuse**, including residents and other nursing home employees. As the representative of the agency charged with enforcing the nurse aide rules, Ms. Lopez had the expertise to determine whether the facts she was presented with constituted **abuse**. The courts generally give deference to the administering agency interpreting its own regulations. *ERICA Inc v. NM Regulation and Licensing Department,* 144 N.M. 132,137, 2008 NMCA 65, ¶11, 184 P.3d 444,449. Petitioner insists that none of this evidence is admissible in a court of law. The nurse aide rules require only that the evidence be reliable. It specifically does not require that it conform to the rules of evidence. The hearing was not held in a court of law. It was an administrative hearing that fully comported with the requirements of DOH rules and the law.

Due process is flexible and calls for such procedural protections as is the situation demands. Petitioner seems really to be saying that even if there were a basis for admission of this abundance of evidence under hearsay exceptions, the foundation to establish those exceptions was not laid. Of course, in the case of documents created or reviewed by Ms. Lopez that would not be true. But, again, this was not in a court of law, and therefore it was not required in any case. Moreover, no objection was made to say, for example, that Petitioner did not believe that the incidents reports were prepared by ABQ Heights and forwarded to DOH as required as a matter of law. 7.1.13. NMAC. No objection was made that the witness statements were not also prepared by ABQ Heights personnel as part of their internal investigation. Absent such an objection, these documents speak for themselves. These is nothing present in this case or evidence offered by Petitioner, that would make the documents seem questionable, or the consistent and repeated reports by more than one resident and staff member of **abuse** to seem anything less than reliable. This is all evidence upon which a reasonable person might rely in the conduct of his/her affairs. It is substantial evidence, and the hearing officer's recommendation and the Secretary's decision was not arbitrary, capricious, and are appropriate as a matter of law.

C. Petitioner Received All the Process Due To Her By Law: Notice and a Reasonable Opportunity to Be Heard.

On March 18, 2010 Petitioner was notified by letter that DOH had concluded, after an investigation, that she had committed **abuse** while working as a CNA. RA 5. It informed her that she had a right to request a hearing, and the right to be represented by an attorney at her own expense. Id. Petitioner did request the hearing, which was held on April 16, 2010.

The New Mexico Supreme Court has stated: "In general, the right to due process in administrative proceedings contemplates only notice of the opposing party's claims and a reasonable opportunity to meet them. *Id.* (emphasis added by Court) *quoting Dente v. State Taxation & Revenue Dep't,* 1997 NMCA 99,¶4, 124 N.M. 93, 946 P.2d 1104, *overruled on other grounds* by *State Taxation & Revenue Dep't v. Bargas,* 2000 NMCA 103, 129 N.M. 800, 14 P.3d 538. There is no question that Petitioner received the notice that an investigation had found she had committed **abuse**, she requested and attended the hearing, and was heard. RA 4, 5, 73; Testimony, RA 81, 83-86, 87-88. She also admitted that she knew that she could bring an attorney to represent her at the hearing, and chose not to. RA 73. She now complains that the hearing officer denied her requested continuance until she could find an attorney. The Hearing Officer considered Petitioner's statement that she had been unable to find an attorney [4], that she had decided to come and hear what they had to say, and then she planned to call an attorney after the hearing. RA 73. Under these circumstances he was not persuaded that a continuance was appropriate. *Id.* [5]

DOH had no prior notice that Petitioner would not want to proceed at the hearing. It brought its employees, one of whom would normally be on survey inspecting facilities in other parts of the state, to the hearing. The DOH's attorney and one witness traveled from Santa Fe for Petitioners convenience as required by DOH rules. 16.12.20.15 (B) NMAC, RA 48. Those same rules require that the hearing be held within 30 days of the hearing request. 16.12.20.15. (A), RA 48. Petitioner says that the DOH could have no legitimate reason to proceed within thirty days of the hearing request. This completely disregards the fact that this serves to protect the individuals who might be harmed if an **abusive** CNA is continuing to work at a nursing home prior to a final determination that is placed on the Registry. Secondly, it would serve to remove the stigma of a pending charge from the record of an accused CNA, should he or she prevail. The hearing officer's determination regarding a continuance is within his discretion, and may only be reversed for **abuse** of discretion. Colonias Development Council v. Rhino Environmental Services, Inc. and NM Environment Dept., 2003 NMCA 141, 588; 134 N.M. 637, 645; 81 P.3d 580, 588, reversed on other grounds 2005 NMSC 24. Based on the facts before him, there was no **abuse** of discretion by the hearing officer.

D. DOH Nurse Aide Registry Rules are in Compliance with Federal Law.

Petitioner is correct that DOH's nurse aide certification rules required that the Department's finding that she committed **abuse** be placed on the registry prior to this Court's hearing of her appeal. 16.12.20.19 through 21 NMAC. In fact, the CNA registry rules required that she be reported to the registry for **abuse** within 10 working days of that finding. 16.12.20.20 NMAC. What Petitioner does not understand is that the certified nurse aide rules were adopted as required by the Social Security Act as it pertains to Medicaid and Medicare. 42 USCS § 1395i(e)(2).

Every state which participates in Medicaid (i.e., every state) must have a registry that identifies individuals that have successfully completed a nurse aide training and competency evaluation program, and is competent to function as a nurse aide in a nursing home. *Id.;* 42 CFR 483.156 (a). Every state's CNA registry is likewise required to report findings of **abuse**, neglect or exploitation of a nursing home resident. 42 USCS §395i-3(g)(1)(C); 42 USCS 1396r(g)(1)(C). These are required elements for any state's Medicare and Medicaid program. 42 CFR 442.100; 42 CFR 430.10.

Applicable Center for Medicare and Medicaid Services (CMS) rules, promulgated by the U.S. Department of Health and Human Services pursuant to this law, provide the framework with which New Mexico must comply in order to participate in the Medicaid Waiver program. The applicable rule states as follows:
(c) Registry Content. (1)The registry must contain at least the following information...

(iv) The following information on any finding by the State survey agency of **abuse**, neglect or misappropriation of property by the individual:

(A)...the nature of the allegation and the evidence...

(B) The date of the hearing... and its outcome; and

(C) A statement by the individual disputing the allegation, if he or she chooses to make one; and

(D) This information must be included in the registry within 10 working days of the finding and must remain in the registry permanently, unless the finding was made in error, the individual was found not guilty in a court of law, or the State is notified of the individual's death.

42 CFR 483.156 (c)(iv)*(emphasis added)*

Therefore, according to the federal law with which the Department's nurse registry rules are required to comply, DOH did what it was required to do when it placed the finding that Petitioner had **abused** residents of a nursing home on the registry. This rule specifically contemplates that the finding may be removed if it is later discovered that it was a mistake, or a court reverses the Department's decision, but it does not permit the Department to wait until that time to act.

Petitioner is also correct that, unlike the employee **abuse** registry (EAR) rules, the nurse aide registry rules do not require a severity review in which the department considers how bad the **abuse** is prior to an individual's placement on the registry. That is because federal law mandates that all findings of **abuse** be placed on the registry almost immediately. It states: "...any finding by the State survey agency of **abuse**...must be included in the registry within 10 working days." 42 CFR 483.156 (c)(iv). The employee **abuse** registry rules are not promulgated pursuant to this law; therefore, the DOH had more discretion. However, the Department believes that even under the EAR rules Petitioner's conduct would have been found to be **abuse**, particularly in the case of Resident 4, who was determined by her IDT to be traumatized by the incident she saw. RA 67. Per the EAR rules, it meets the severity standards if "the **abuse** causes significant mental anguish as evidenced by the victim's descriptions, or significant behavioral changes." 7.1.12.11 (A)(5). Resident 4 seemed depressed, and was crying because of Petitioner's **abuse** of her roommate, and said she was frightened of Petitioner. Two months later she could still clearly, and emphatically, report what she had seen.

Federal law also prohibits removal of the CNA's name from the registry if they have been found guilty of **abuse**. This is made clear because the ONLY ground for removal of an adverse finding from the registry is that if the finding relates to neglect. 42 USCS §1396 r (g)(1)(D). New Mexico's rule follows that mandate.

The public policy evident in the CNA registry law and related federal and state rules is clear. The federal government, acting through HHS/CMS, believes that after the CNA has had a "reasonable opportunity for a hearing for the individual to rebut allegations," [6] and been found to have **abused** a resident, the state's interest must be to protect other residents in nursing homes who might also be **abused** were it to wait until all appeals are exhausted. The federal government also has decided that **abuse** is **abuse**, and it is not acceptable. Therefore it gives no second chances. The Department is given no discretion in this matter. For it to do otherwise would jeopardize other nursing home residents. It could also impact the state's Medicaid program eligibility, impacting not just Petitioner, but all the Medicaid recipients in New Mexico.

CONCLUSION

All of the arguments regarding the problems Petitioner felt she was having with the supervising nurse, and her argument that this case was just evidence that ABQ Heights discriminates against African Americans, were raised and addressed at her hearing. The Hearing Officer considered and rejected those arguments based upon the evidence he heard. DOH encourages this Court

to review the hearing officer's comprehensive 21 page review of the evidence, and his recommendation which was adopted, not lightly but properly, by the Secretary of Health.

The credible evidence provided by Petitioner showed that she had had a long, hard day of work. She had not had a break for hours. RA 85. She started at 6:00 a.m. and didn't get lunch until nearly three o'clock. According to Resident 4, Petitioner seemed mad, like she didn't want to be there. RA 76. That seems likely. The problem is, she took it out on the residents of the nursing home. That is totally unacceptable. [7]

The Petitioner's interest is to protect her "property interest" in a nurse aide certificate, which must be obtained by a CNA, and requires "not less than 75 hours" of training, i.e., about two weeks. 42 USCS §396r (f)(2). The DOH's interest is to protect other nursing home residents from **abuse**. It is the that Petitioner may no longer be a certified nurse aide because the evidence overwhelmingly showed that she **abused** ABQ Heights' nursing home residents. That does not mean she may not work in some other capacity as a healthcare worker. The nurse aide registry only applies to certified nurse aides. It will not prevent her from obtaining other gainful employment, even in the healthcare arena. However, the DOH cannot help but hope that Petitioner will seek some other form of employment for which she may be better suited.

WHEREFORE, Respondents respectfully request that this Court affirm the New Mexico Secretary of Health's decision, and grant such other and further relief as this Court deems just.

Dated: May 2, 2011

Respectfully submitted,

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Footnotes

1 The record is replete with evidence to support the allegations, and is not limited to those cited.

2 Petitioner objects that the interpreter was not certified. Neither the DOH nor the facility is required to use certified interpreters, there is no indication that the interpreter was inaccurate, and this objection was not made at hearing, and therefore is waived.

3 DOH believes that this should be Princeton Place, another facility in Albuquerque, NM.

4 Petitioner's assertion in her brief that she had used her best efforts to find an attorney prior to the hearing is very doubtful in light of the fact that the hearing took place on Friday, April 16, 2010, and her present attorney sent a letter by fax to DOH one business day later, the following Monday, April 19, 2010. RA 10.

5 Even in a criminal matter, where typically right to counsel arguments arise, one is not entitled to counsel for all purposes. For example, in New Mexico, administrative parole revocation hearings in which an individual's parole from imprisonment may be lost, there is no right to counsel at all. *See e.g.*, *Robinson v. Cox*, 77 N.M. 55; 419 P.2d 253 (1966). In administrative hearing about involuntary anti-

psychotic drug administration cases for prison inmates there is likewise no right to counsel. *Washington v. Harper*, 494 U.S. 210, 110 S. Ct. 1029, 108 L. Ed. 2d 178 (1990). Moreover, had Petitioner wished to bring counsel she could have. What she could not do was first decide to go without counsel, then change her mind after everyone had assembled for the hearing.

6 42 USCS §1396r (g)(1)(C)

7 One has to wonder if this has not happened on other occasions. Petitioner's statement that she was accused of breaking one man's shoulder at Princeton Place raises troubling questions.

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