

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F211569

JENNIFER SPURLOCK	CLAIMANT
BEVERLY HEALTHCARE - VAN BUREN	RESPONDENT
CONSTITUTION STATE SERVICES INSURANCE CARRIER	RESPONDENT

OPINION FILED JULY 28, 2003

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Fort Smith, Sebastian County, Arkansas.

Claimant represented by R. GUNNER DELAY, Attorney, Fort Smith, Arkansas.

Respondent represented by J. GREGORY MAGNESS, Attorney, Fort Smith, Arkansas.

STATEMENT OF THE CASE

A hearing was held on May 1, 2003, in Fort Smith, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on March 5, 2003. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

By agreement of the parties the following stipulations were submitted to the Commission for its consideration:

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On September 8, 2002, the relationship of employee-employer-carrier existed between the parties.
3. The claimant earned an average weekly wage of \$211.87.

By agreement of the parties the issues to litigate are limited to the following:

1. Compensability of the claimant's right hand and wrist injuries.
2. Related medical.
3. Temporary total disability from September 21, 2002, to a date to be determined.
4. Attorney's fees.

In regard to the foregoing issues the claimant contends that she sustained a compensable right wrist injury on September 8, 2002, while lifting a resident in the scope and course of her employment. She contends that she is entitled to temporary total disability benefits from September 21, 2002, to a date yet to be determined.

In regard to the foregoing issues the respondent contends that they have controverted the claim as not compensable and states that there is no objective medical evidence to support the injury. Additionally, respondents state that there was light duty work available for claimant at her regular rate of pay.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing Order marked Commission's Exhibit No. 1. The claimant submitted medical reports marked Claimant's Exhibit No. 1 and a letter from Dr. Sherrill marked Claimant's Exhibit No. 2. The respondents submitted medical reports marked Respondents' Exhibit No. 1, the Deposition of Claimant marked Respondents' Exhibit No. 2, and a statement from the claimant marked Respondents' Exhibit No. 3. All of these exhibits were submitted without objection.

DISCUSSION

The claimant testified that she was a nurse's aid in training working for the respondent on September 8, 2002. The claimant testified that she went into a patient's room and found him on the floor. The claimant stated that she got the charge nurse, Lauren, and when the two of them tried to get the resident into a wheelchair he began fighting with them. The claimant testified that a maintenance man came in to help. The claimant testified that Lauren was on one side of the patient, the maintenance man was on the other side of the patient, and she was between them and went underneath the client to try to lift him. The claimant testified that she had her hands underneath the claimant's armpits and that as they were lifting him she heard a pop in her right wrist. The claimant testified that usually this particular patient is a one person lift but he was fighting them because he did not want to get off the floor. The claimant testified that she began to feel discomfort in her right wrist immediately and told Lauren about her problem. The claimant stated that Lauren sent her to Carrie Strahan, who is the Assistant Director of Nursing.

The claimant testified that when she reported her incident to Ms. Strahan, Ms. Strahan had her write out an incident report on a piece of paper and then Ms. Strahan called Crawford County Memorial Hospital and told the hospital that they were sending a workers' compensation patient over to be examined. The claimant testified that she was then instructed to call and get a ride to the hospital. The claimant testified that in the emergency room she

gave a report as to how her accident happened and she had x-rays of her arm taken. The claimant testified that she was given a foam splint and sent back to work on light duty. The claimant testified that she returned to work and at about 7:30 p.m. her arm began to really bother her and she was sent home. The claimant testified that she was already scheduled to be off the next day, the 9th, but did report back to work on the 10th. The claimant testified that she worked regular duty on the 10th and did work her entire shift. The claimant testified that her report from the emergency room had gotten lost, therefore, she was placed on regular duty. The claimant testified that she finally located the missing report from the emergency room and slid it under Carrie Strahan's door since she had already left for the evening. The claimant testified that she was seen by Dr. Baker on the 11th and he took her off work for a week. The claimant testified that she saw Dr. Baker at the request of the respondent and when she saw Dr. Baker she described how her injury happened. The claimant stated that she sees Dr. Baker for an unrelated medical problem called chronic obstructive pulmonary disorder. The claimant testified that Dr. Baker agreed with the respondent that the claimant could return to work just answering the telephone and doing light duty such as take vital signs and passing ice. The claimant testified that when she returned to work she was put back on the hall doing regular duty such as lifting and turning patients. The claimant testified that she was still wearing her arm brace but that she was told that they did not have anyone else to do the job.

The claimant testified that on the 21st of September, she developed an upper respiratory infection and bronchitis and, after being seen by a doctor, was taken off work for this problem for four days. The claimant testified that when she called in to see if she was on the schedule, she was instructed to call Tammi Angel, the Director of Nursing. The claimant testified that she spoke with Tammi and was told that she had been terminated for verbally abusing one of the residents. The claimant testified that to her knowledge, she has never been written up for verbal abuse of a resident but that once one of her supervisors had pulled her aside and given her a stern talking to for using such a gruff tone when speaking to the residents.

The claimant testified that she had seen Dr. Baker on the 11th and 18th of September and that he then referred her to Dr. Sherrill, an Orthopedist. The claimant testified that she saw Dr. Sherrill on September 26th and had seen him five or six times for her hand and wrist problems. The claimant testified that she was then referred to a Neurologist, Dr. Griggs, who diagnosed her with having a tardy ulnar nerve pausing in her arm for which surgery was recommended. The claimant testified that surgery has been denied and that she is still experiencing problems with her right hand and wrist. The claimant testified that she experiences sharp pain, her elbow constantly stays sore, she has no feeling in her little finger or the side of her ring finger on her right hand. The claimant testified that she could use her right hand for about five minutes and then she starts dropping things. The claimant

testified that even though she has a respiratory problem, she would be working at present except for her hand problems. The claimant testified that no one will hire her until she is released from the doctor.

On cross examination, the claimant testified that it was the respondent's procedure that if a resident is found on the floor she was to get the charge nurse. The claimant testified that when she and Lauren, the charge nurse, were trying to get the resident up into his wheel chair, he was fighting them so the maintenance man came in to help. The claimant agreed that all three, the claimant, Lauren, and the maintenance man were involved in picking up the resident. The claimant agreed that the Lauren and the maintenance man were on either side of the resident and she was behind the resident during the lift. The claimant further agreed that when she was off from the 21st of September through the 25th of September, it was not for her wrist but was due to a bronchial infection.

The claimant testified that she called into the respondent on the 26th and found out that she had been terminated. She testified that she talked with Tammi Angel, the Director of Nursing, and was told that she was discharged for no call/no show. The claimant testified that she disputed this dismissal and then Ms. Angel told her she had been terminated due to verbal abuse of a resident. The claimant testified that she had not verbally abused a resident but had insisted that he take a shower since he had not had one in a

week. The claimant was asked if she had used any profanity and she responded "no."

The claimant testified that she has looked for work in this area but has not had any success until she is released as to her right-hand problems. The claimant agreed that she can use all of her body parts except for her right hand and wrist and agreed that she is capable of doing light duty which does not require right-handed work. The claimant testified that her chronic pulmonary condition would not stop her from working and that she had even let her Social Security application lapse. The claimant agreed in her deposition that she had testified that her COPD condition, which is a chronic pulmonary condition, had her totally disabled and further agreed that in her deposition she had testified that it is difficult for her to even walk across the room because of this pulmonary condition. The claimant testified at the hearing that she would rather be working than staying at home and that is why she has let her Social Security application lapse. The claimant testified that she now uses Dr. Baker for her pulmonary treatment but that she first began to see him as a result of her wrist problems. The claimant also agreed that from February 8 through February 12 of 2003, she had checked herself into Harbor View and that her reason for checking herself into this hospital had nothing to do with her wrist. The claimant again testified that she is again in Harbor View and that this is her second day in the hospital. The claimant again agreed that the reason for checking herself into Harbor View had nothing to do with her wrist.

The respondent called Lauren Sardinha as a witness. This witness testified that she is currently unemployed and had last worked the end of February 2003. Ms. Sardinha testified that she last worked for the respondent as an LPN and was a charge nurse. Ms. Sardinha testified that she was the claimant's charge nurse and remembers the event when the claimant found one of the residents on the floor. This witness testified that she was at the nursing station when the claimant came up and reported that a resident was on the floor so she went immediately to the room. Ms. Sardinha testified that the resident is difficult to understand and was trying to ascertain what had happened from the resident. Ms. Sardinha got one of the housekeepers, Howard, who got on one side of the patient and she was on the other side, and they were trying to lift the resident into his wheelchair. This witness remembers that the claimant was in the back of the wheel chair holding it steady. Ms. Sardinha stated that this resident was very difficult to handle because he has cerebral palsy and was kind of fighting with herself and Howard as they were trying to lift him. This witness testified that the claimant was standing behind the wheelchair to stabilize it so it would not go back and forward. Ms. Sardinha testified that the claimant did not help with the lift of the resident that she and Howard did the lifting. Ms. Sardinha testified that the claimant did not say anything to her initially about being injured but that later on Carrie Strahan, the Assistant Director of Nursing came up to her and asked if the claimant had reported to her an injury and this was the first time that she had

heard anything about the claimant being injured. Ms. Sardinha stated that later on the claimant came up and told her that she had hurt herself lifting the resident. This witness testified again that the claimant had no contact with the resident when the three of them were in the room however she does not know if the claimant did something before they got in the room.

On cross examination, Ms. Sardinha testified that she had voluntarily terminated her employment with the respondent. This witness further agreed that the claimant was in the room with the resident when he was being lifted up off the ground. This witness testified that she does not remember the claimant placing her arms and hands under the resident's armpits. Ms. Sardinha testified that when the claimant reported to her that she had hurt her wrist lifting a resident, she had told the claimant, "I don't know how you did that. Howard and I were - we were the ones that lifted him. How can you hurt yourself?" This witness testified that the Assistant Director of Nursing had asked her to fill out a statement concerning the event, which she did. Ms. Sardinha agreed that it was possible that she didn't notice if the claimant had her arms placed underneath the resident's armpits during the process of trying to get the resident seated into the wheelchair since there was so much commotion going on. On redirect, this witness again stated that, to her memory, the claimant was never near the resident when she was in the room assisting with the lift. Ms. Sardinha further testified that at no time did she and the claimant

try to lift the resident before the maintenance man came in to help.

The respondent called Tammi Angel who testified that she was the Director of Nursing Services for the respondent business. Ms. Angel testified that she was not at work on September 8, 2002. This witness testified that the first she knew about the claimant's complaints of injury was when she saw paperwork on her desk concerning the matter the following day. Ms. Angel testified that she does recall the claimant being on light duty because of her wrist and light duty work was provided for her. Ms. Angel testified that it was not true that the respondent did not give the claimant light duty work but put her back to full duty on the CNA schedule. Ms. Angel testified that she had a telephone conversation with the claimant concerning the claimant's termination for not calling in and not showing up for work. Ms. Angel testified that she never saw any type of note from the doctor concerning the claimant and putting her on light duty. This witness further testified that she does not recall a note concerning taking the claimant off work during September 2002. Ms. Angel testified during this same conversation with the claimant she discussed with the claimant the allegation that she had verbally abused one of the residents. This witness testified that she gave the claimant the opportunity to write a statement on her behalf concerning the verbal abuse allegation but that she never came in to fill out this statement.

On cross examination, Ms. Angel testified that she does believe she remembers the claimant being taken off work after she was first seen by Dr. Baker. Ms. Angel testified that if there was a note placing the claimant on light duty, she would have been put on light duty but she does not remember a doctor's note instructing that the claimant could only answer the telephone. Ms. Angel testified that during the conversation with the claimant she does not recall the claimant telling her that she brought a note excusing her from work and that she gave this note to the third shift nurse. This witness testified that there was a written report concerning the allegations of the claimant verbally abusing a resident and remembers that this event occurred on the last day the claimant worked for the respondent. Ms. Angel testified that there were two witnesses to the verbal abuse incident, explaining that one was a CNA, Susan Harris, but the other lady's name she could not recall. Ms. Angel testified that these two CNA's were in the room during the incident.

The medical record set forth that the claimant was seen at Crawford Memorial Hospital on September 8, 2002 for problems with her right hand and wrist. The hospital records indicate that she was lifting a resident and felt or heard a pop. The claimant was diagnosed with a wrist sprain, prescribed a wrist splint, and returned to work at light duty with no use of the right hand. X-rays taken of the claimant's hand showed no fracture or dislocations. The claimant was seen by Dr. Robert Baker on September 11, 2002, where he notes that the claimant has complaints

of pain in her right wrist from lifting a patient at work on the 8th when she apparently got off balance and her wrist got bent backwards. After examination, Dr. Baker diagnosed the claimant with a sprain to her right wrist, took her off work for a week and prescribe medication. A note dated September 12, 2002 indicates that the claimant can return to work at light duty where she could answer the telephone and such. Dr. Baker writes on September 18, he has again seen the claimant noting that she has been on light duty but had to lift someone which caused her extreme pain. Dr. Baker writes that the claimant wants the day off to rest her wrist before going back to work. On examination, the doctor writes that the claimant is exhibiting extreme pain when her wrist is touched but that there is no edema, deformity or ecchymosis, and range of motion could not be tested. Dr. Baker referred her to an orthopedist, did not take her off work but did write a note stating she could do no lifting and pulling. The claimant was then seen by Dr. William Sherrill on September 26, 2002. Dr. Sherrill notes that the claimant reports that her pain is in her right wrist at the distal radial ulnar joint on the ulnar side of her wrist. Dr. Sherrill notes that the claimant has no swelling or deformity and her range of motion is not bad but she complains of pain. Dr. Sherrill switched her from her splint which she had been using and recommended that she use an elastic type wrap to support her wrist, noting that with some time her problem should heal. Dr. Sherrill notes that the claimant's x-rays are normal and she can continue light duty work. The claimant was seen at the Sparks Regional

Medical Center emergency room on September 29, 2002, indicating that she had numbness in her right hand and her hand was sore, noting that this area was in the wrist area. The claimant was again seen by Dr. Sherrill on October 9, 2002, for her wrist problem, noting that her pain is better. Dr. Sherrill notes that the claimant does have some swelling but cautioned the claimant about wrapping her wrist too tight. Dr. Sherrill also cautioned the claimant about resting her elbow and elevating the hand because this seems to be aggravating her ulnar nerve problem. Dr. Sherrill writes that he understands that the claimant is currently not working but he does not feel that she is ready to go back to work. Dr. Sherrill writes on October 18 that the claimant's distal radial ulnar joint pain is better with her wrap around splint but she is still having a little swelling in her hand and numbness in the ulnar nerve distribution. The doctor writes that the claimant has quite a bit of sensitivity of the ulnar nerve at the elbow and that may have been causing her pain since that is now the biggest part of her symptoms and it bothers her to flex and extend the elbow. The claimant reported that all of her problems got worse when she was changed to a different type of job that involved flexing and extending the elbow and the doctor notes that this may be what precipitated her problem. The claimant underwent an NCV on October 21, 2002, which indicated that she has mild tardy ulnar palsy in her right hand. This test indicated that there was no evidence of any defused neuropathy. Dr. Sherrill writes on October 28, 2002, that the claimant's NCV confirmed that the claimant has tardy ulnar

nerve palsy on the right and he did feel the ulnar nerve subluxing back and forth and she does indicate that she has bumped it, meaning her elbow, numerous times. Dr. Sherrill recommended that a transposition and a decompression of the ulnar nerve be performed on the claimant's right elbow. Dr. Sherrill writes on October 30 that over the course of his treatment of the claimant, her symptoms have gradually expanded to include numbness of the ulnar side of the hand and pain on the medial aspect of her elbow consistent with ulnar nerve irritation. He notes that the NCV indicates that she has tardy ulnar palsy and the claimant reports that she has frequently bumped the medial aspect of her elbow while at work.

After a review of this entire record, I find that the claimant has failed to prove by a preponderance of the evidence that she sustained a compensable injury to her right wrist and hand on September 8, 2002, while working for the respondent. The claimant has testified that she felt something pop in her right wrist when helping to lift a resident on that date. The claimant's charge nurse who assisted with the lift of the resident has testified that the claimant was only holding the wheelchair to steady it so that she, the charge nurse, and a maintenance man could get the resident up into the wheelchair. It is true that the claimant reported an injury and received medical treatment on the date of her alleged injury. The claimant had no objective findings of injury except for her complaints of pain and was diagnosed with a strain at that time and treated therefore. As time progressed, the claimant's complaints of discomfort migrated to the side of her right hand and

then eventually up to her elbow. Following an NCV exam, the claimant was diagnosed with tardy ulnar nerve palsy. Dr. Sherrill has set forth in his notes that the claimant indicates that she had frequently bumped the medial aspect of her elbow where the ulnar nerve is at work. Dr. Sherrill further writes that this obviously would irritate the ulnar nerve. The claimant has not testified to any bump to her elbow which would result in the problems which she is experiencing. It may be that the claimant temporarily sprained her wrist while working on September 8, 2002, but an injury to her elbow or wrist caused by bumping it has not been testified to by the claimant. Therefore, I find that the claimant's current problems with her right forearm did not arise out of and in the course of her employment with the respondent.

FINDINGS & CONCLUSIONS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On September 8, 2002, the relationship of employee-employer-carrier existed between the parties.
3. The claimant earned an average weekly wage of \$211.87.
4. The claimant has failed to prove by a preponderance of the evidence that she sustained a compensable injury while working for the respondent on September 8, 2002. See discussion above.

ORDER

The claimant has failed to prove by a preponderance of the evidence that she sustained a compensable injury while working for

the respondent on September 8, 2002. Therefore, this claim for benefits should be denied in its entirety.

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE