

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F704162

CANDISE LACHANCE	CLAIMANT
LOVE SHACK LLC	RESPONDENT
FIRSTCOMP INSURANCE CO. INSURANCE CARRIER	RESPONDENT

OPINION FILED NOVEMBER 5, 2007

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Springdale, Washington County, Arkansas.

Claimant represented by EVELYN BROOKS, Attorney, Fayetteville, Arkansas.

Respondents represented by WILLIAM FRYE, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on September 25, 2007, in Springdale, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on May 24, 2007. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

The following stipulations were submitted by the parties and are hereby accepted:

1. The Arkansas workers' Compensation Commission has jurisdiction of this claim.

2. On December 23, 2006, the relationship of employee-employer-carrier existed between the parties.

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

1. Compensability of the claimant's injuries to his left leg and ankle on December 23, 2006.

2. Related medical.

3. The claimant's appropriate compensation rate.

4. Attorney's fees.

In regard to the foregoing issues the claimant contends that she was injured on December 23, 2006. Her left leg, knee and ankle were injured when she fell off of a chair.

In regard to the foregoing issues the respondents contend that the claimant suffered an alleged injury on December 23, 2006, when she states that she fell out of a chair. However, the respondents contend that they have no information to support a compensable injury, and/or medical records to show objective measurable findings to support a compensable injury. Furthermore, the claimant came in during November limping and stated to the respondent/employer that she had fallen off a friend's porch.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted documentation marked Claimant's Exhibit No. 1, Claimant's Exhibit No. 2, and Claimant's Exhibit No. 3. The respondents submitted documentary evidence marked Respondents' Exhibit No. 1, Exhibit No. 2, and Exhibit No. 3. All these exhibits were admitted without objection.

#### DISCUSSION

The claimant testified that she was fifty-six years old and began working for the respondent in the early part of September

2006 as a waitress. The claimant testified that she worked on an average of twenty-five hours per week. The claimant testified that the two owners worked at the restaurant and were always there when she was working. The claimant testified that in late December 2006 at approximately 9:00 in the evening she had gone to the back part of the restaurant to unplug the Christmas lights which were plugged into the ceiling. The claimant testified that she slipped off the chair she was standing on and as she was falling she hit her head on the table. The claimant testified that when she hit the ground her left knee and leg hit first and she landed on her left side. The claimant testified that immediately she had excruciating pain and could not get up or put any weight on her leg. The claimant testified that the two owners and a dishwasher were present. The claimant testified that she laid on the floor and yelled for one of the owners and that Catherine helped her get to one of the booths. The claimant testified that she sat there for about ten or fifteen minutes and that Catherine came out of the kitchen and told her to get up and walk on it but she told Catherine that she could not so the dishwasher carried her out to her car. The claimant testified that the respondent did not offer to take her to a doctor nor did they fill out any paperwork. The claimant testified that she drove to her house and that her son-in-law carried her in.

The claimant testified that the next morning her daughter drove her to the hospital in Berryville. The claimant testified that in the ER her leg was examined, x-rayed, she was given a shot for pain, and prescribed medications. The claimant testified that

from the ER her daughter took her directly to the respondent's business and she reported how bad her leg was. The claimant testified that again no paperwork was filled out and no offer to send her to a doctor was made.

The claimant testified that she did not seek medical treatment right away because she did not have any insurance. The claimant testified that she was seen by Dr. Dean Kirkpatrick who made a house call to administer treatment. The claimant testified that she has been treated by Dr. Kirkpatrick in the past for maintenance and she saw him for probably seven or eight house calls. The claimant agreed that Dr. Kirkpatrick ordered an MRI and after her MRI she was seen by Dr. Dan Bell. The claimant testified that Dr. Bell put her in a whole leg brace to keep it immobile and referred her to Dr. Hanby who gave her steroid injections in her knee. The claimant testified that she is to return to Dr. Hanby in one more month for another injection. The claimant testified that she is still having problems of swelling and pain in her left knee.

The claimant testified that about a month before her accident she had a fall but was able to go to work and do her job. The claimant testified that she was sore but she could do her work. The claimant testified that she had soreness in her left knee for approximately two to three days but she did not seek medical attention of any kind for this fall. The claimant remembered that this fall occurred approximately two months before her fall while working for the respondent. The claimant testified that she believes that she worked until Christmas Eve for the respondents

but did not work any after her accident. The claimant agreed that up until her accident she had been working regularly for the respondent.

On cross examination, the claimant testified that she has had neck surgery in the past to repair a herniated disc. The claimant agreed that after her surgery she continued to have some weakness in both her upper and lower extremities and that the numbness in her legs went all the way down into both of her feet. The claimant agreed that after her neck surgery in 2003 she was placed on permanent light duty restrictions. The claimant testified that she has tried to limit her lifting to about ten to fifteen pounds. The claimant was asked about the fall which she had in November 2006. The claimant testified that as a result of this fall her leg was sore but she was able to work. The claimant testified that as a result of this fall she jarred her left knee. The claimant testified that after she quit working for the respondent she filed for unemployment in January 2007 in Arizona. The claimant testified that she received \$240 per week from Arizona for unemployment. The claimant testified that during the period of time she was collecting unemployment she also filed for social security or SSI. The claimant agreed that from January until late February she was not being treated or seen by a doctor. The claimant explained that the reason she had put on some of her disability paperwork that she became unable to work on February 27, 2007, was because that was the date that she determined that she was unable to be a waitress because of her leg. The claimant

agreed that there was a two-month gap from the time she was seen at the ER until she was next seen by a physician and during this period of time she was looking for work and collecting unemployment. The claimant testified that when she was seen at the Eureka Christian Health Outreach on February 22, 2007, she reported to them that the day before the pain in her knee intensified. The claimant agreed that February 22, 2007, is also the date that she reported to social security as the date she became disabled. The claimant testified that the doctor at the Eureka Health Outreach gave her a different leg brace. The claimant testified that the doctors at this clinic told her that she could not work because she could not walk on her leg but they did not give her an off work slip. The claimant agreed that she was also seen for blood pressure problems. The claimant agreed that when she was seen again on March 8, 2007, at the Outreach Clinic she reported having problems with neuropathy or nerve problems from her neck injury. The claimant testified that specifically she was having neuropathy in her left knee but that she also had problems with her right knee and leg as well. The claimant indicated that when she was seen at the Outreach Clinic on March 22, 2007, she was seen for health problems unrelated to her knee. The claimant testified that when she was seen on March 22 she was taking Advil for knee pain, high blood pressure medication, and another pain medication. The claimant was shown a medical report from Dr. Bell dated April 26, 2007, and was asked if she saw anything on this report that indicated that the doctor was treating her for her knee. The

claimant responded, "I don't know." The claimant did agree that the medications which Dr. Bell had her on at that time were for anxiety and her nerves. The claimant testified that she has treated with Dr. Kirkpatrick for several years for maintenance. The claimant testified that Dr. Kirkpatrick came to her home to assess how bad her knee was. The claimant testified that she first was seen by Dr. Kirkpatrick for her left knee problems but agreed that in April 2007 she was seen by Dr. Kirkpatrick for back problems. The claimant agreed that after the house call which Dr. Kirkpatrick made to her he started treating her for her low back not her knee and this was after her knee problems had intensified in February. The claimant testified that when she was seen at the Eureka Family Medical Clinic in August 2007 it was for back pain. The claimant remembered that she then was seen at the Washington Regional Family Clinic at Eureka Springs for low back pain. The claimant testified that she also listed as symptoms swelling in her knee, joint pain in her knee, paralysis which was a neuropathy as well as headaches, and other problems such as acid stomach and symptoms related to menopause. The claimant was also being treated for neck pain. The claimant testified that her reports of joint pain, muscle pain, and spasms are related to her leg but the numbness, tingling, burning, and shooting pains as well as weakness, paralysis, and headaches are related to her neck and back problems. The claimant remembered that at this visit she had an x-ray made of her cervical spine. The claimant testified that when she was working for the respondent she was paid by check every two

weeks. The claimant testified that the entry data setting forth that she began working on October 13, 2006, and ended her employment with the respondent on December 1, 2006, is incorrect. The claimant testified that she got eight or ten checks from the respondent and remembers specifically that she was working in September because she worked on her birthday, September 17. The claimant testified that currently she is taking steroid injections for her knee as well as pain medications which are prescribed by Dr. Bell. The claimant testified that she would disagree with the records which indicate that she was not working in late December for the respondent. The claimant testified that she has been looking for work in places where she could sit a little because she cannot sit for a very long time because of her leg and back. The claimant testified that the primary reason she cannot sit for a long period of time is because of her knee. The claimant explained that because of the way her knee is it throws her back out. The claimant explained that the reason she filed for and collected unemployment from January to March was because she thought she was still employed by the respondent. The claimant further explained that in Arizona it is legal to file for unemployment if you have a guaranteed job to go back to within a certain period of time and she thought she had a guaranteed job with the respondent. The claimant explained that she filed for social security because the way her leg was she could not walk that far, could not sit that long, and could not walk the way she used to because she had torn cartilage and several fractures in her knee. The claimant

testified that the atrophy which she has in certain parts of her body is due to her neck surgery but that has not kept her from being able to do her work. The claimant agreed that on the days she worked they would add up her hours as well as her tips. The claimant was shown a document and was asked if the figures looked accurate as far the amount of her tips and wages and the claimant responded, "Yes." The claimant produced a pay record which eventually was determined set forth earnings for the claimant from the respondent on the top part of the document and from a former employer, Sixty Two Diner, on the bottom part of the document. It was agreed that after discussion that the record would be left open for fourteen days from the date of this hearing in order for the claimant to secure her additional pay stubs while working for the respondent which she had indicated that she had in a file at home.

On redirect examination, the claimant testified that prior to her fall while working for the respondent she did experience numbness and tingling in her legs and arms but she did not have a problem with her left knee. The claimant testified that Dr. Bell referred her to a specialist, Dr. Hanby, an orthopedic surgeon. The claimant testified that after her injury she complained to her doctors about her knee and she told them what was wrong with her knee.

Amy Ward testified that she is one of the owners of the respondent business. Ms. Ward testified that the claimant was paid every two weeks by check. Ms. Ward testified that all records are sent to the bookkeeper, Linda Lombardo, so that payments can be

made for the business. Ms. Ward was shown a couple of documents and identified one of these documents as the earning records for the claimant. Ms. Ward identified the second document as a report which they had the bookkeeper prepare for social security. Ms. Ward testified that this document shows that the claimant began working for the respondent on October 20, 2006, and ended her employment on December 1, 2006. Ms. Ward testified that the claimant did not work any for the respondent past December 1, 2006. Ms. Ward testified that in late November the claimant reported that she had fallen off of a friend's porch at Holiday Island and her knee was hurting but she still worked. Ms. Ward testified that the claimant quit working because her knee continued to bother her and their season was shutting down. Ms. Ward testified that the claimant was not working for the respondent on December 23. This witness testified that the claimant did not report a fall on December 23. Ms. Ward did recall that the claimant and her daughter did stop by the restaurant at some point and that the claimant was complaining about her leg hurting from her porch fall.

On cross examination, Ms. Ward testified that she was saying that the claimant did not fall unplugging Christmas lights. This witness testified that she does not remember the name of the dishwasher that was working in December 2006. Ms. Ward did testify that whoever was their dishwasher at that time no longer is there. Ms. Ward testified that the respondent does have colored lights around their windows and they are plugged into the ceiling. Ms. Ward testified that in order to plug or unplug the lights they use

a URL stepladder. Ms. Ward testified that she had no idea of the date that the claimant fell off the porch in November just remembering that it was sometime in late November. This witness testified that the claimant continued to work after her fall at a friend's house until December 1. Ms. Ward testified that the respondent was first contacted about this claim by their attorney. Ms. Ward was shown a Form AR-2 and read the portion dealing with controversion to set forth, "No med information to substantiate injury." Ms. Ward testified that there was no information on the controversion portion dealing with the claimant not being employed or working on December 23, 2006. Ms. Ward agreed that if there had been an injury at the respondent's business paperwork would have been filled out and it would have been sent to the insurance company. Ms. Ward testified that she did not tell the claimant that she would not turn in the paperwork because they did not want to make their insurance rates rise.

The medical records set forth that the claimant was seen at St. John's Hospital in Berryville on December 24, 2006, with complaints of a fall injuring her left knee while employed by the respondent. Upon examination, in the ER it was noted that the claimant had swelling in her left knee as well as other reported symptoms. In the narrative assessment it is noted that the claimant reports severe pain to her left knee since a fall at work the last PM, fell off a chair, hit back of hand/head, and fell onto left knee. X-rays taken on December 24, 2006, of the claimant's left knee were normal. The claimant was diagnosed with having a

strain to the left knee, medications were prescribed and she was released. A medical report which is marked as Claimant's Exhibit No. 1, Page 1, which the parties have agreed should be dated either March or April 2007 indicates that the claimant was seen by Dr. Dan Bell on March 8 and again on the 22 at which time she was fitted with a knee brace and medications were prescribed for stress. This report also sets forth that the claimant had an onset of problems to her left knee on December 23, 2006, due to a fall from a chair at work at the respondent's business. The claimant's major complaints at the time of this report were low back pain and stiffness, left knee pain, and stiffness with swelling. The claimant was seen at the Eureka Christian Outreach on February 22, 2007, where she reports that she fell shortly before Christmas at work and injured her left knee. The claimant reports that her knee problems have not improved and yesterday her pain intensified for no known reason. This office note sets forth that the claimant has worn a brace since her injury but this brace allowed slight bending of the knee and that the claimant has noticed loss of muscle in her leg. The examiner observed that the claimant's left knee looked unremarkable with no swelling but she reports tenderness over the medial meniscus. The claimant was assessed with left knee pain with a possible medial meniscus ligament injury. The claimant was placed in a different knee brace and recommended to use crutches. The claimant was seen by Dr. Dean Kirkpatrick on February 28, 2007, with complaints of low back, leg, and knee pain. The claimant returned to the Eureka Health Outreach Clinic on March 8, 2007,

where it is noted that she was fired from her job and is stressed with this situation. On examination, the claimant reports pain in her left knee but the examiner notes that she has good range of motion of this knee and that there is no swelling. It is further noted by the examiner that the claimant's x-rays show normal knee. The claimant was given instructions and medications were recommended as well as a follow up visit after her MRI. When the claimant was seen at the Eureka Outreach Clinic on March 22, 2007, she was treated only for her hypertension, anxiety, and GERD. An MRI of the claimant's left knee was done on July 19, 2007, which revealed a non-displaced tibial plateau fracture, a sprain of the ACL but no definite tear and a vertebral tear involving the root attachment of the posterior horn of the lateral meniscus. There was also moderate swelling with a small moderate Baker's cyst. The claimant was seen at the Eureka Family Medical Center on August 2, 2007, with complaints of severe lower back pain noting that she was injured on December 23, 2006, when she fell off a chair injuring her left leg. After review of the claimant's MRI and examination, the doctor assessed the claimant with having a tibial plateau fracture on the left, suspected meniscal and or collateral ligament strain, chronic low back pain, and a history of anxiety. The doctor recommended x-rays as well as medications and a referral was made to Dr. Hanby, an orthopedic doctor. X-rays of the claimant's cervical spine reveal degenerative changes with disc space narrowing at the 5-6 level and views of the claimant's left knee revealed demineralization, no fracture or displacement, and joint

space is maintained. The impression of the claimant's left knee was degenerative changes. The claimant was seen by Dr. Kirs Hanby on August 31, 2007, for complaints to her left knee. After physical examination, Dr. Hanby notes that the claimant's x-rays demonstrate what appears to be a healed lateral tibial plateau fracture with minimal displacement. The doctor also notes that the claimant's MRI demonstrates what appears to be a tear at the root of the lateral meniscus as well as the changes from her lateral tibial plateau fracture. Considering these findings, Dr. Hanby assessed the claimant as status post lateral tibial plateau fracture with meniscal injury. Dr. Hanby notes that the claimant's situation may require an arthroscopy to debride her lateral meniscus, however he would prefer to try steroid injections for the next couple of months before an arthroscopy is done.

The respondents' medical exhibits set forth a early history of the claimant's medical problems primarily dealing with pain in her back and headaches. On June 3, 2003, the claimant was seen for problems with her legs and arms since February 2003 resulting from doing heavy lifting. An MRI was recommended by Dr. R. Lee Archer and eventually the claimant underwent surgery to repair a herniated disc at C6-C7. Dr. Ali Kirsht who was the claimant's surgeon reports a month or so after her surgery on August 12, 2003, that the claimant is improving and shows good alignment. Dr. Kirsht, at this time, gave the claimant some dos and don'ts as to her physical activities.

The respondents' non-medical information dealing with the claimant's earnings set forth that the claimant was first paid by the respondent on October 20, 2006, where it indicates that she was paid \$120 in gross wages and \$120 in tips, for the paycheck dated November 3, 2006, the claimant earned \$207 and earned tips in the amount of \$892, check dated 11-17-06 indicates the claimant earned \$160 and \$349 in tips, and check dated 12-1-06 the claimant was paid \$80 in wages and received \$140 in tips. This report indicates for the period of time from October 1, 2006, through December 31, 2006, the claimant was paid \$510.60 in gross wages and \$1,504.00 in tips. The claimant signed an employee's withholding statement, a W4, claiming six deductions noting that the claimant signed this W4 on October 13, 2006. The respondents made a report to the Social Security Administration on June 18, 2007, indicating that the claimant began her employment with the respondent on October 13, 2006, and her employment ended with them on December 1, 2006. This report indicates that in year 2006 in October the claimant earned \$246, in November \$1,548.60, and in December \$220. This form is signed by Linda Lombardo the payroll clerk for the respondent. On page 6 of Respondents' Exhibit No. 2 which is an application summary for a supplemental security income the claimant indicates that her disability began February 27, 2004.

After a complete review of this entire matter, I find that the claimant has failed to prove by a preponderance of the credible evidence that she sustained a compensable injury while working for the respondent on December 23, 2006. The claimant has been unable

to provide any corroborating testimony as to her injury nor has she been able to provide any evidence that she was employed by the respondent on December 23, 2006. It is noted that the claimant specifically stated that she recalls that she was working in September because she worked on her birthday, however the w4 which she signed for the respondent when she went to work for them is dated October 13, 2006, and the respondent's payroll records indicate that the claimant was paid her first check on October 20, 2006. Therefore, based on what I perceive to be the more credible evidence in this matter as well as the documentation presented as evidence, I find that the claimant has failed to meet her burden of proof that she sustained a compensable injury while working for the respondent.

#### FINDINGS & CONCLUSIONS

1. The Arkansas workers' Compensation Commission has jurisdiction of this claim.
2. On December 23, 2006, the relationship of employee-employer-carrier existed between the parties.
3. The claimant has failed to prove by a preponderance of the credible evidence that she sustained a compensable injury while working for the respondent on December 23, 2006.

#### ORDER

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

working for the respondent on December 23, 2006. Therefore, this claim should be denied in its entirety.

IT IS SO ORDERED.

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ELIZABETH DANIELSON  
ADMINISTRATIVE LAW JUDGE