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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Appellate Panel
Commissioner Derrick L. Williams
Commissioner T. Scott Beck
Commissioner Avery B. Wilkerson, Jr.

WCC File No. 0815441

Margaree Maple, ... Claimant/Appellant

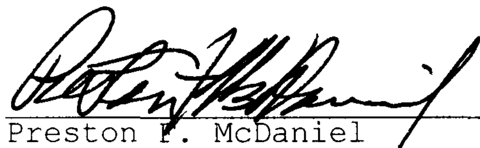
v.

Heritage Healthcare of Ridgeway, Employer,
and Phoenix Insurance Company, Carrier . . . Defendants/Respondents.

NOTICE OF APPEAL

Claimant Margaree Maple appeals the Order of the South Carolina Workers' Compensation Appellate Panel dated August 27, 2012. Appellant received written notice of entry of this Order on August 27, 2012.

Dated: September 26, 2012



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RECEIVED
SEP 26 2012
SC Court of Appeals

GROUNDS/ALLEGED ERRORS OF LAW

Margaree Maple v. Heritage Healthcare of Ridgeway
W.C.C. File No. 0815441

The following grounds and/or alleged errors of law are presented to the Court for a decision:

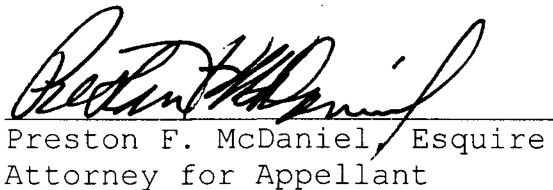
1. That the Commission erred in issuing the Order in that it did not have jurisdiction over the matter since this matter was pending before the South Carolina Court of Appeals and in the South Carolina Supreme Court and is currently pending before the South Carolina Supreme Court on a Petition for Writ of Certiorari.

2. That the Commission erred in violation of its statutory responsibility by failing to make detailed Findings of Fact and Conclusions of Law in violation of all the statutes that apply to the issuance of Order under the Administrative Procedures Act and the Workers' Compensation Act.

3. That all of the previous grounds for appeal from the original Orders of the Commission are incorporated herein by reference as part of the grounds to this appeal to the South Carolina Court of Appeals.

The above-referenced Exceptions are subject to amendment.

Respectfully submitted,



Preston F. McDaniel, Esquire
Attorney for Appellant

September 26, 2012

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Appellate Panel
Commissioner Derrick L. Williams
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WCC File No. 0815441

Margaree Maple, ... Claimant/Appellant

v.

Heritage Healthcare of Ridgeway, Employer,
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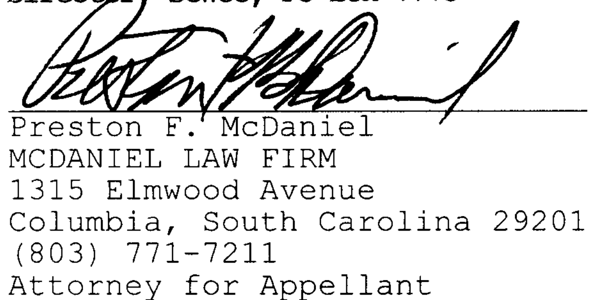
PROOF OF SERVICE

I certify that I have served the **NOTICE OF APPEAL** on the Respondents by depositing a copy of it in the United States Mail, postage prepaid, on **September 26, 2012**, addressed to its attorney of record, R. Daniel Addison, Esquire, Hedrick, Eatman, Gardner & Kincheloe, Post Office Box 11267, Columbia, South Carolina 29211. **and Virginia L. Crocker, Judicial Director, SCWCC, PO BOx 1715 Columbia, SC 29202**

Dated: September 26, 2012



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Proudly representing injured workers for over 25 years.

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September 26, 2012

The Honorable Jenny Abbott Kitchings
Clerk, SC Court of Appeals
Post Office Box 11629
Columbia, South Carolina 29211

RE: Margaree Maple, Claimant/Appellant v. Heritage Healthcare of Ridgeway, Employer, and Phoenix Insurance Company, Carrier, Defendants/Respondents.
WCC File No. 0815441

Dear Ms. Kitchings:

Enclosed for filing is a Notice of Appeal in the above case. Also enclosed are the following:

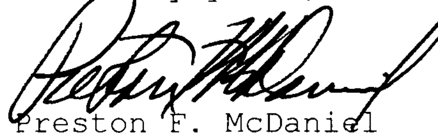
1. Proof of Service of the Notice of Appeal on the Respondents;

2. a copy of the Order, which is to be challenged on appeal; and

3. a Filing fee of $100.00.

I would appreciate your filing the original and returning a clocked-in copy to me in the enclosed, self-addressed, stamped envelope.

Sincerely yours,



Preston F. McDaniel

PFM/kth
Enclosures

cc: Ms. Virginia L. Crocker, Judicial Director, SCWCC
R. Daniel Addison, Esquire
Honorable Daniel Shearouse

RECEIVED
SEP 26 2012
SC Court of Appeals

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. FILE No.: 0815441

Margaree Maple, Claimant/Appellant, vs. Heritage Healthcare of Ridgeway, and Phoenix Insurance Company, Carrier, Defendants/Respondents.	)	**AMENDED & REVISED DECISION & ORDER OF THE FULL COMMISSION**

Appellate Panel Review held in Columbia, South Carolina on April 20, 2010 per notices timely and properly served on all parties of interest.

Appellate Panel Decision and Order filed 8/27, 2012

APPEARENCES: Claimant/Appellant represented by Preston F. McDaniel, of Columbia, South Carolina

Defendants/Respondents represented by R. Daniel Addison, of Columbia, South Carolina

STATEMENT OF THE CASE

This case was heard before Commissioner Andrea Roche on February 9, 2009, in Columbia, South Carolina. The parties agreed that the claimant has not reached maximum medical improvement and that she was still under the care of Dr. Roger Gaddy for her work-

related injury. Thus, the parties agreed that continued treatment with Dr. Gaddy will be provided to the claimant until he releases her from care.

The claimant took the position that the defendants owe her temporary total disability benefits because she never returned to work for them at light duty prior to her termination. The claimant also contends that she is entitled to further temporary total disability benefits from the date she was released to light duty to the date she was released to full duty, the dates of that period are September 9, 2008 to January 13, 2009.

The defendants, however, contend that the claimant falsified a work excuse which led to her termination and that she failed to maintain proper contact with her employer following her injury. The defendants took the position that this behavior constitutes an unjustified refusal of suitable work, thus disqualifying the claimant from her right to temporary total disability benefits. The claimant denied this allegation and maintains that she is entitled to the benefits in question. The defendants also noted for the record that they admit the claimant suffered a minor injury to her knees when she fell at work, landing on her knees; the defendants denied any additional injuries.

Commissioner Roche issued her Decision and Order on December 16, 2009 holding in pertinent part that the claimant, or someone on her behalf, falsified work excuse documentation; that the claimant failed to maintain proper contact with her employer; that this behavior constituted an unjustified refusal of suitable employment; and that due to her unjustified refusal of suitable employment, thus, the claimant is not entitled to any temporary total disability compensation. Commissioner Roche did not decide the issue of which body parts were affected by the injury.

On December 23, 2009, the claimant appealed Commissioner Roche's decision, alleging multiple grounds for error. In summary, the claimant contested the Hearing Commissioner's findings that the claimant's behavior following her injury amounted to refusal of suitable employment, which barred the claimant from receiving temporary disability benefits. Defendants contend that there is reliable, probative, and substantial evidence in the record to support the findings of the Hearing Commissioner, and asked that the Full Commission affirm the Hearing Commissioner's Decision and Order in its entirety.

On June 16, 2010, the Full Commission entered a Decision & Order affirming the Hearing Commissioner's decision and adopted the findings and conclusions of the Hearing Commissioner verbatim. Claimant appealed the Full Commission's Decision & Order to the South Carolina Court of Appeals. The Court of Appeals issued an order on June 27, 2012 affirming the Full Commission's Decision & Order in part and remanding the matter for a clarification of the Full Commission's ruling. In accordance with the Court of Appeals' order, the Full Commission has issued this Amended & Revised Decision & Order wherein the Commission restates and reissues its previous order verbatim except where specific findings have been separately stated to address the points of clarification deemed necessary by the Court of Appeals.

EVIDENCE OF THE CASE

At the hearing, the claimant testified on her own behalf. The claimant stated that she was fifty-seven (57) years old and she went to school through part of the tenth (10th) grade. She lives in a trailer on her own land with her daughter and her three (3) grandsons. The claimant stated that since she left school she has worked in home healthcare, at nursing homes, and for the defendant/employer. She noted that she does have her CNA license.

The claimant stated that the name of the defendant/employer's facility has changed over the years, but that she has worked at that location off and on for about twenty-five (25) years. She testified that she initially worked there for about twenty (20) years, but left for about a year before returning. The claimant stated that in the year she was away from the job, she did not work. She testified that her job duties were to care for residents at the facility.

The claimant stated that her work injury occurred on August 31, 2008 at dinner time. She testified that she was passing out food trays to the residents when she slipped in some water that was on the floor. She stated that she fell to the floor landing on her hands and knees. The claimant testified that her immediate pain was in both of her knees and nothing else was really bothering her at the time, though she noted that her right arm began to bother her later on.

The claimant testified that her co-worker, Branch, helped her off the floor and into a chair. She stated that Tonya Sheppard, the nurse in charge, was also present when the incident occurred. The claimant explained that her sister, who also works for the defendant/employer, came to pick her up from work and Ms. Sheppard instructed her to go to the emergency room at that time. She stated that her sister drove her home and her daughter took her to the emergency room.

The claimant went on to explain that she didn't have a car available to her on a regular basis. She stated that she usually walked to work in the afternoons and caught a ride home from co-workers at night when her shift ended. The claimant testified that her shift was from 3:00 p.m. to 11:00 p.m. and that her typical schedule included four (4) days on and two (2) days off. She stated that she was injured on August 31, 2008 and was scheduled to work the following day on September 1, 2008.

The claimant testified that she went to the hospital after the fall and had her legs examined. She said that the doctor looked at her legs and gave her some pain medication. She explained that they pushed her in a wheelchair from the hospital back to the car and her daughter and the hospital staff helped her into the car. The claimant testified that her daughter picked up the paper work as they left the hospital. She recalls that the work note from the hospital told her she could return to work on September 4, 2008.

The claimant testified that the work note was handed to her at the hospital by the doctor. The claimant verified that the work note in evidence was the actual note given to her by the doctor. She asserted that she took the note to work and gave it to Lynda Burr. The claimant said that she believed she took the note in on September 2, 2008, but she isn't sure about the date. She went on to testify that when she was supposed to return on September 4th, her legs were hurting still and she called in to Sherry Goodwin and told her that she would not be able to come in that day.

The claimant stated that she also asked to have an appointment with a doctor set up since she was still in pain. She said that Ms. Burr was going to make her an appointment for that Friday, but she explained to Ms. Burr that she didn't have a car because her daughter would be using it to go to work that day and she had no way to get to the doctor then. She testified that Ms. Burr made the appointment anyway. The claimant stated that she missed the appointment.

The claimant testified that she did come back to work on Saturday and Sunday of that week. She stated that she did reset her appointment for September 9th with Fairfield Family Practice. The nurse practitioner examined the claimant's legs again and gave her some more medication. The claimant was also provided with a work note taking her out of work until

September 18, 2008. The claimant testified that on that first visit, she was told to return to see Dr. Gaddy on the 16th.

The claimant stated that she returned to see Dr. Gaddy as scheduled. She explained that he examined both of her knees and her right arm and gave her some pain medication. The claimant stated that she had a conversation with Dr. Gaddy regarding some contact that Ms. Burr had with his office. Dr. Gaddy told her that Ms. Burr wanted to know what kind of light duty the claimant could do so that they could accommodate her. The claimant went on to testify that Dr. Gaddy asked her what kinds of things people do when on light duty with the defendant/employer. She stated that she told him that people would make beds, pass out ice, and take blood pressure while on light duty. The claimant asserted that Dr. Gaddy did not want her doing those things and gave her a work note that held her out of work until the 30th unless sedentary work could be provided.

The claimant testified that she took the note from Dr. Gaddy to work that day and gave it to Ms. Burr. She further testified that Ms. Burr did not offer her any sedentary work that day when she took the note in, and that she has not been offered any work since that day. The claimant also testified that she was not told that she was suspected of falsifying her work note. She asserted that is was several days later, on the 17th or 18th, that she received a note with her paycheck notifying her that she had been terminated for falsifying documents.

The claimant testified that her follow-up visit with Dr. Gaddy was on September 30th and she did tell him on that occasion that she had been fired. The claimant testified that on September 30, 2008, she reported to Dr. Gaddy that in addition to the pain in her knees, she was periodically getting a pain in he right shoulder that was like a numbness running down her arm to her hand. The next report from Dr. Gaddy is dated January 13, 2009, but the claimant stated that

she had been to the doctor between those times. She noted that she needs refills of her pain medications for her legs and she went to his office but did not actually see Dr. Gaddy.

The claimant testified that when she returned to Dr. Gaddy on January 13, 2009, she was in the process of trying to get unemployment benefits. She explained that losing her job has been very difficult on her financially. The only way she would be approved for unemployment was if Dr. Gaddy would sign a note saying that she had been released from treatment. The claimant asserts that she would work if she could and she would work light duty if it was offered to her. She stated that the defendant/employer has not offered her any form of work since the point at which she was informed of her termination.

The claimant testified that she is still having pain in her knees. She stated that when she goes to stand after sitting, it causes pain in her knees. She stated that her legs also hurt when she stretches them certain ways. The claimant also asserted that her arm still has the tingling sensation. She stated that the tingling makes her drop things sometimes. She stated that she would like more medical treatment for these problems. The claimant asserted that she did not have any problems with her arm before the work accident.

On cross-examination the claimant confirmed that she could not remember the exact date that she brought in the work note from the emergency room, but she asserted that she was certain that it was before September 4th, the date the note said she could return. The claimant recalled speaking to Ms. Goodwin when she brought the note in and recalls saying to Ms. Goodwin that she didn't think she'd be able to come back to work on the 4th. The claimant testified that she did not have a note holding her out of work on September 4th, only the note from the emergency room saying that she could return that day.

The claimant also confirmed that her testimony regarding the appointment arranged by Ms. Burr was that she sat in Ms. Burr's office while the appointment was being scheduled and protested that she could not go on the day suggested but Ms. Burr set the appointment despite her protests. The claimant again stated that she did not have a car and that her daughter was at work at the time and couldn't drive her. The claimant admitted that she did have a driver's license, and noted that there was not anything preventing her from driving her daughter to work and borrowing the car. The claimant asserted that she'd never driven her daughter's car before. She said she knows how to drive but chooses not to drive.

The claimant also testified that the contact number given to her employer is actually her daughter's cell phone number. She stated that there is no land line at their home. The claimant noted that her grandsons sometimes answer her daughter's phone. She admitted that if Ms. Burr noted calling the number provided and speaking with a young man, it was possible that one of her grandsons had answered the phone.

The claimant also clarified on cross-examination that the work note from the hospital was not given to her by the doctor but by the nurse. The claimant also noted that she has been dealing with high blood pressure for a long time and confirmed that she was aware of the condition before the accident. She insists that she takes her blood pressure medication daily as directed.

The claimant testified that she and her husband have been separated for about two (2) years but have not gone through a divorce. She noted that he no longer lives with her. Interestingly, she testified on direct examination that she and her husband get along and that he takes care of her.

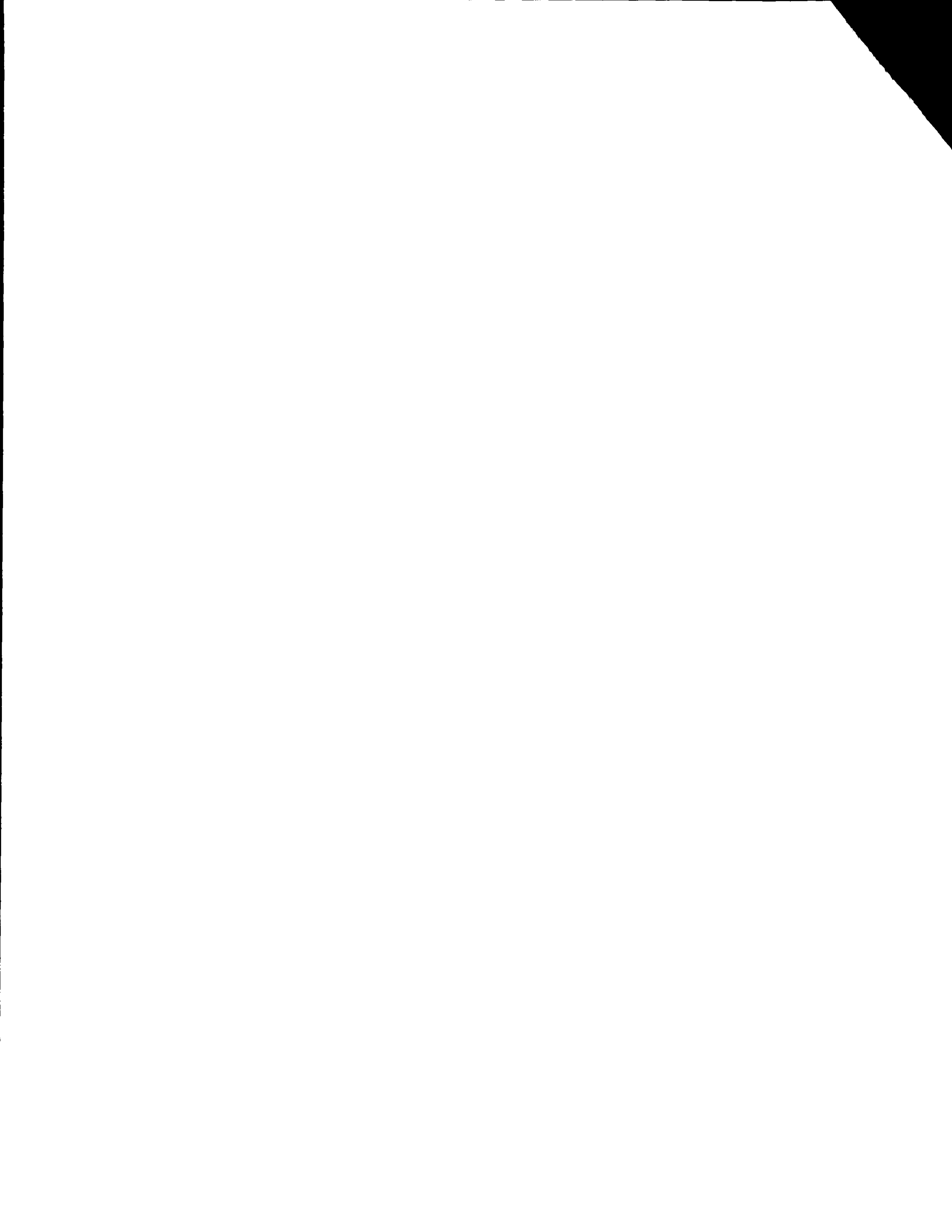
The claimant was again asked if when she took the work note from the ER in to her employer if she personally handed the note to anyone, to which she responded in the negative. She stated that she was sure she took the note in before September 4th. She further stated that she went back to work on a Saturday, and the office at the facility is not open on Saturdays, so she would have taken it before then. The claimant was told that Ms. Burr would testify that the claimant brought the paperwork in a week later, after much hounding by Ms. Burr. The claimant stated that there was some possibility that the events occurred that way.

The claimant also testified that she did not see any other doctors besides Dr. Gaddy between September 30, 2008 and January 13, 2009. She stated that she did not ask to see any other doctors during that time. She testified that she was allowed to return to get pain medication during that time period but noted that she paid for her own prescriptions.

The claimant stated that she was not sure why Dr. Gaddy asked her what light duty would consist of instead of asking Ms. Burr. She also noted that she is not an administrator at the facility and has not set up any light duty for other employees, nor has she ever worked light duty herself. She stated that she based what she told Dr. Gaddy about light duty on her own observations from working at the facility.

The claimant testified that she has looked for other work since the accident. She stated that she heard of a job doing in-home healthcare but when she inquired about it the position had already been filled.

On re-direct examination, the claimant asserted that she did not alter the work-note from the hospital in any way, nor did anyone she knows. She contended that the note was given to her employer in the exact condition in which she received it from the hospital.



The claimant was asked to walk so that the Commissioner could observe her gait. She walked with a limp. The claimant stated that her knee hurts when she stands up and her legs hurt after walking a certain length of time. She stated that her left knee bothers her more than her right.

The claimant was re-cross examined and testified that her legs were bothering her when she saw Dr. Gaddy on January 13, 2009, and that she informed Dr. Gaddy of the problems with her legs. A portion of the visit note was read to the claimant, in which Dr. Gaddy reported that the claimant "states ready to go back to work, states no pain to left knee." The claimant insisted that she told the doctor that her legs were hurting.

The defendants called Lynda Burr to testify. Ms. Burr testified that she is the Human Resources Generalist for the defendant/employer and that she has worked there for six (6) years. She stated that part of her job duties are to deal with workers' compensation claims.

Ms. Burr testified that she was out of work on August 31, 2008, when the claimant's accident occurred, but was informed of the claimant's accident when she returned to the office. She stated that she was informed that the claimant had not returned to work since the date of the accident. Ms. Burr testified that she made several attempts to contact the claimant by telephone and left several messages requesting a return call. Ms. Burr stated that the claimant's sister, Johnnie Mae Butler, who also works at the facility, offered to go to the claimant's house and ask her to get in touch with Ms. Burr.

Ms. Burr went on to testify that she finally spoke with the claimant on September 3, 2008, when the claimant came in to pick up her paycheck. She stated that she also arranged for the claimant to go to the doctor because she had not been treated by any provider other than the ER at that point. Ms. Burr testified that the claimant sat in her office while the appointment was

arranged and the date was verified. The claimant confirmed that the appointment of Friday, September 5, 2008, was fine. Ms. Burr said that the doctor's office later notified her that the claimant missed the appointment.

Ms. Burr testified that the claimant was taken out of work initially, and later put on modified duty. Ms. Burr confirmed that she did contact Dr. Gaddy about modified duty for the claimant. She stated that they always ask the doctors to consider modified duty if medically possible because they are generally able to accommodate the modifications. She noted that modified duty would depend on the needs of the individual, and they verify if sedentary duty will allow the patient to sit, stand, or change positions. Ms. Burr testified that the claimant could have been given sedentary work such as trimming residents' nails, answering the telephone, or sitting and folding laundry.

Ms. Burr testified that the claimant did not bring in the hospital work note on September 3, 2008, when they first talked about the accident. She stated that the claimant returned to work and still had not provided the work note from the hospital. Ms. Burr stated that she told the claimant that the work note was needed to be sure they were following her restrictions. She also testified that the claimant did bring in the note within a day or two of returning to work.

Ms. Burr explained that the claimant only provided her with the work note from the emergency room. She stated that when she received it, she questioned the date given for return to work. Ms. Burr noted that in her experience with the emergency room, they only excuse people from work for the day of treatment unless the injury is very serious. The ER providers generally instruct patients to follow up with their family doctor for further treatment. Because she questioned the validity of the note, Ms. Burr contacted the ER at Fairfield Memorial. One of the staff members confirmed that ER doctors don't write patients out for extended periods of

time. Ms. Burr stated that she later received a discharge note from the claimant's ER visit that stated the claimant could return to work on September 1st, **not September 4th**. The evidence indicates that this document was received by the defendant/employer on September 17, 2008.

Upon receipt of the discharge report indicating return to work on September 1, 2008, Ms. Burr informed her supervisor of her concern that the original hospital work status note had been altered. She stated that because it appeared that the doctor's note had been falsified, the decision was made that the claimant would be terminated. Ms. Burr explained that, other than the issue with the falsification of the medical records, the company had no problems bringing the claimant back to work on modified duty. She stated that arrangements had been made to return the claimant to modified duty but she had been unable to reach the claimant to get her back in to work. Ms. Burr noted that the claimant's sister had gone to the claimant's home on several occasions, but no one answered the door. She stated that she tried everything she could think of to get the claimant to come in to work.

On cross-examination, Ms. Burr stated that the claimant had some disciplinary notes in her file due to attendance in the past. She stated that to her knowledge, the claimant was a good employee though.

Ms. Burr stated that the claimant sat with her while the doctor's appointment was scheduled for September 5th. She stated that the claimant told her that as long as her daughter didn't have to work that she'd be able to go to the appointment. Ms. Burr said that she advised the claimant to let her know if the appointment needed to be moved. Ms. Burr testified that everything on the date of the injury was done properly but the claimant did not follow-up with the employer properly after that. She stated that the claimant brought in the work note from the September 9, 2008 visit, but the note merely took the claimant out of work with no modifications

or explanations. Ms. Burr tried to contact the claimant on the 11th and 12th regarding the situation but was unable to reach the claimant. She was informed that the carrier had also been unsuccessful in contacting the claimant.

Ms. Burr stated that she was trying to contact the claimant about the possibility of working light duty and that she also contacted Dr. Gaddy to ask about the possibility of modified duty. She stated that she wanted the claimant to see Dr. Gaddy in order to determine if any modified duty would be medically possible for the claimant. Ms. Burr testified that she also attempted to contact the claimant regarding the injury and her work status by sending the claimant a letter by UPS Overnight on September 15, 2008. This letter in included in the record. The letter noted the other attempts that Ms. Burr had made to contact the claimant and noted that the claimant had a release to return to work on September 12, 2008, from the nurse practitioner at Dr. Gaddy's office.

Ms. Burr testified that she could not say for certain whether the claimant knew that Dr. Gaddy had approved the modified duty, as the note was sent to Ms. Burr but the claimant was instructed to keep in frequent contact with Ms. Burr and failed to do so despite Ms. Burr's many attempts to initiate contact with the claimant. She stated that the claimant would not come in long enough to talk to anyone about modified duty once Dr. Gaddy approved modified duty and assigned restrictions. Ms. Burr explained that after the claimant's appointment on September 16th, the claimant left her work note at Ms. Burr's office on her door but did not speak to anyone. She stated that the note was merely dropped off and the claimant did not ask if she would be given modified duty, nor did the claimant follow up later to see if she would be assigned to work.

Ms. Burr testified that the decision was not made to fire the claimant until September 18, 2008, when further documents were received from the Emergency Room which made it appear

that the claimant's original work note was falsified. Ms. Burr stated that she wanted the claimant to come in and discuss the emergency room records with her but, again, the claimant would not respond to Ms. Burr's attempts to contact the claimant.

Ms. Burr explained that falsification of documents is grounds for immediate termination, even for an employee with a good work record. She testified that because the claimant would not get in touch with her or the supervisor, they had nothing to go on other than the appearance that the work note was falsified. Ms. Burr noted that the other documents from the emergency room indicated that the claimant could return to work on September 1, 2008, and that the work note appeared to have the "1" altered to be a "4."

Ms. Burr admitted that no offer of sedentary work had been made directly to the claimant. She stated that the claimant had been asked on several occasions, by telephone message, by letter, by note on her paycheck, and by sending someone to the claimant's house to contact Ms. Burr or a supervisor about modified duty. The claimant never followed-up with anyone in that regard, so no offer of sedentary work could have been made directly to the claimant due to the claimant's malfeasance.

The medical records indicate that the claimant was seen on August 31, 2008, at Fairfield Memorial Hospital Emergency Room after a fall at work. The claimant was diagnosed with a left knee contusion, and her x-rays showed some degenerative changes in the claimant's knees without other abnormality. The discharge sheet from the Emergency Department notes that the claimant may return to work on September 1, 2008, and she may limit her activities as tolerated. (A.P.A. No. 1, p. 3). The separate work slip from the Emergency Department indicates return to work for September 4, 2008; however, it is observed that the "4" is in darker print than any of the other writing on the note. (A.P.A. No. 3, p. 21).

The claimant first saw Dr. Roger Gaddy on September 9, 2008, with complaints of bilateral knee pain. Dr. Gaddy prescribed anti-inflammatories and counseled her on some gentle range of motion exercises for her knee as well as concerns for controlling her blood pressure more effectively. Dr. Gaddy's records do show that Ms. Burr left a message with the doctor's office notifying them that light duty work could be provided to the claimant and asking whether the doctor felt that light duty would be possible for the claimant. In response to this message, a new work note allowing sedentary work was faxed to Ms. Burr by Dr. Gaddy's staff.

The claimant returned to Dr. Gaddy on September 16, 2008 with continued complaints of knee pain. She stated that her knees were still bothering her and she was taking Advil instead of the prescription anti-inflammatory medication. The claimant also had complaints of chest pressure and headaches, for which Dr. Gaddy adjusted her blood pressure medication. The claimant was also switched to alternate medication for her knees. Dr. Gaddy made no note of whether or not he discussed the claimant's work status with her during that visit.

The claimant's next visit with Dr. Gaddy was on September 30, 2008. On this occasion she still complained of bilateral knee pain and offered new complaints of intermittent numbness in her right arm. Dr. Gaddy noted crepitance in both knees on exam, but no effusion or increased warmth was found. The claimant was advised to follow up in four (4) weeks; however, the next note from Dr. Gaddy was not until January 13, 2009.

On the date of the January visit, the claimant reported that her knees were no longer painful, she had good movement, and that she was ready to return to work. The claimant's exam appeared generally normal, with some concern for her high blood pressure, and no mention of right arm pain was made on this visit.

The Deposition of Dr. Russell A. Ross was submitted into evidence. Dr. Ross was the physician who treated the claimant during her visit to the Fairfield Memorial Hospital Emergency Department on the day of her injury. Dr. Ross was shown the original work status note given to the claimant at the Emergency Room. Dr. Ross stated that the handwriting on the note was not his. He explained that the note was probably written by Star Connor, one of the nurses. Dr. Ross stated that he would not have had a part in preparing the work status note but rather it would have been handled by his nurse. Dr. Ross testified that Ms. Connor would have prepared the note based on instructions that he gave her but that the note itself would be fully prepared by Ms. Connor. Dr. Ross explained that this would be the standard procedure for preparing work status notes in the Emergency Department.

Dr. Ross noted that he's been working in emergency medicine for about twelve (12) years, basically the majority of his career. He noted that he is on contract with several different hospitals, including Fairfield Memorial, Abbeville, Manning, and Kingstree.

Dr. Ross confirmed that he was working at Fairfield Memorial on August 31, 2008, when the claimant presented with a left knee contusion. He confirmed that it was his handwriting on the claimant's reports from that visit. Dr. Ross also confirmed that it was his handwriting on the emergency room discharge sheet noting that the claimant could return to work on "9/1/08."

Dr. Ross went through the Emergency Department exam sheet regarding the claimant. He explained that the claimant came to the ER shortly after the injury occurred and that she complained of left knee pain. The sheet showed that the examination of the claimant was negative for any symptoms other than left knee pain. Dr. Ross testified that the claimant made no complaints beyond left knee pain.

Dr. Ross testified that the records appear correct in returning the claimant to work on September 1, 2008, the day after the injury. He stated that it seems normal based on his review of the records that the claimant would be returned to work the following day. Dr. Ross stated that based on the findings in the exam, returning the claimant to work the next day would be standard and he sees no reason that the claimant would have been kept out of work for several days.

On cross-examination, Dr. Ross testified that the paperwork may vary from hospital to hospital but the examination procedure is essentially the same in all emergency rooms where he works. Dr. Ross explained that after the doctor examines a patient in the ER, he will give any orders to the nurse for medications and discharge then the nurse essentially handles the discharge of the patient. Dr. Ross stated that the nurse may take care of any questions that the patient has before discharge. He said that the nurse could have changed the "1" to a "4" on the work status note during discharge of the claimant. Dr. Ross admitted that he had no specific recollection of the claimant. He stated that his testimony was based from his review of the documents provided and his usual practices.

Dr. Ross explained that a diagnosis of "contusion" was a fairly broad term. He stated that it essentially means some degree of bruising without any fracture or damage to the bone. He testified that his notes indicate that there was no visible swelling in his examination of the claimant but the left knee was tender to pressure. Dr. Ross stated that the nurse's notes were not included in the claimant's medical records but those notes could be helpful for anything that was discussed between the claimant and the nurse.

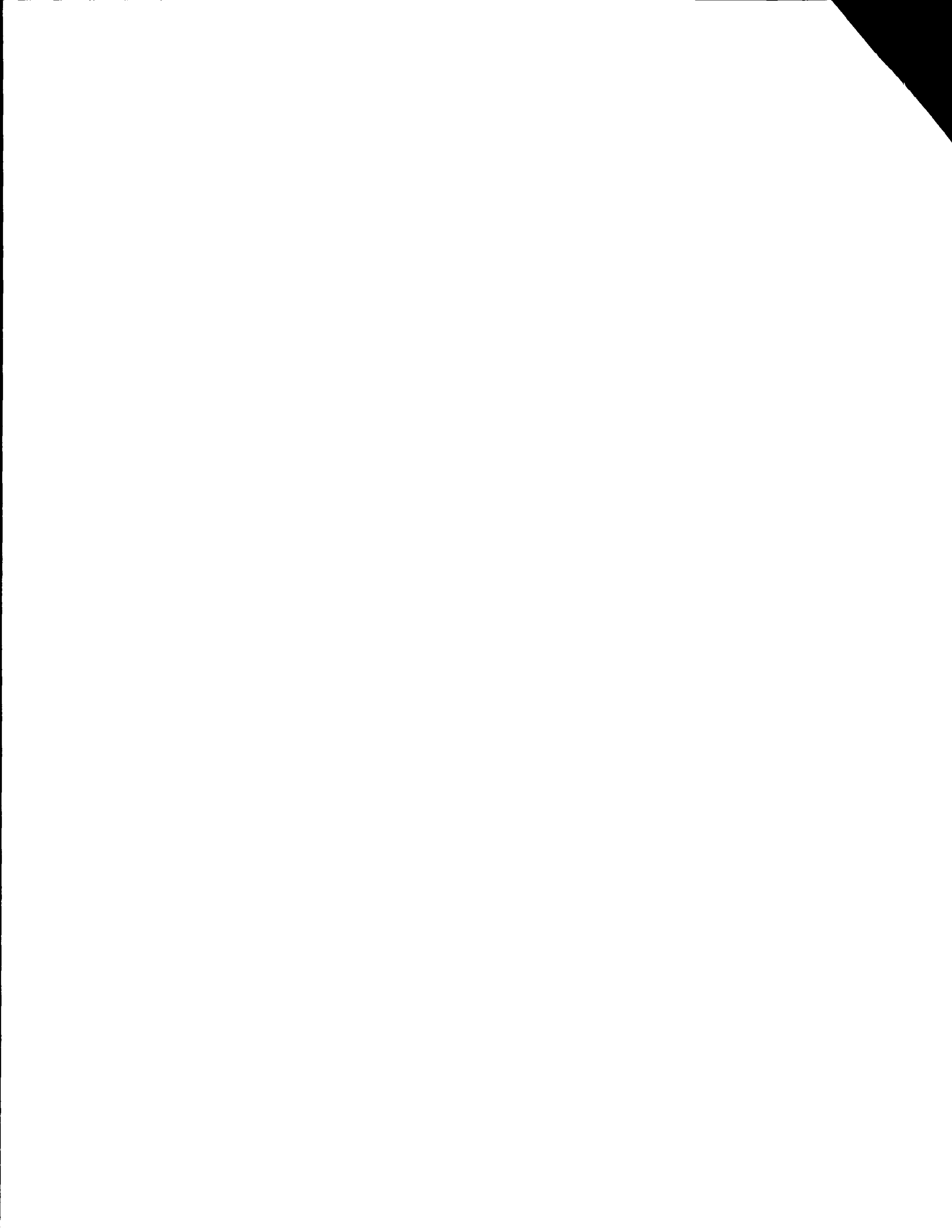
Dr. Ross stated that a nurse could have changed the work status form. He stated that the nurses will typically clear that sort of thing with the doctor first but may not have if the ER was

busy at the time. Dr. Ross testified that there could be a number of possibilities but he doesn't know what the particular situation was in this case. Dr. Ross testified that his personal recommendation was that the claimant could return to work the next day on September 1, 2008.

The deposition of Star Connor was also taken and submitted into evidence. Ms. Connor confirmed that she is an RN at Fairfield Memorial Hospital and that she works in the Emergency Department. Ms. Connor stated that she worked for the facility now owned by the defendant/employer in the past and knows the claimant from her work there. She noted that she just knows the claimant in passing and did not actually work with the claimant. She was on a different shift. She also confirmed that she has not actually worked for the defendant/employer, but for the company who owned the facility previously.

Ms. Connor stated that she has worked as a nurse in Orthopedics, an adult day care, the nursing home, and in the Emergency Room. She stated that she has worked in the ER since she started at Fairfield Memorial seven (7) years ago. She explained that the ER at Fairfield is fairly small and operates much like a clinic. They do mostly walk-in care, and if there is a bad case, the patient will be stabilized and sent to a larger hospital. Ms. Connor testified that there is usually only one (1) doctor, one (1) or two (2) nurses, and one (1) CNA working in the ER at any given time.

Ms. Connor testified that the hospital administration determines how paperwork is to be done in the ER. She also stated that she cannot specifically remember her dealings with the claimant. She explained that patients are typically checked quickly when they first come in to see whether they need to be treated urgently, and, if not, they will be sent back to the lobby to complete paperwork before being seen by the doctor. After the doctor examines the patient and decides what should be done, the doctor will write the discharge notes, and the nurse will handle



the actual discharge of the patient. Ms. Connor stated that some doctors write their own work status notes but that Dr. Ross typically did not. Instead, he would fill in return-to-work instructions on his discharge notes and tell the nurses to write the actual work status note.

Ms. Connor was shown the work status note given to the claimant at the Emergency Room. She immediately stated that the note had been changed. Ms. Connor verified that the note was written by her and that she recognized the writing as her handwriting. She testified that she would have filled out the note per Dr. Ross's instructions and signed it "Dr. Ross/S. Connor." She verified that the date of care was indicated as "8/31/2008" and that this information was correct. Ms. Connor testified that the date indicated in the Return to Work blank had been changed. She testified that she would have filled it out as September 1, 2008, as indicated in the doctor's orders. She pointed out that the work status note indicated "9/4/208", which does not match the doctor's orders, and that she does not write her fours in the same manner that was on the note.

Ms. Connor further testified that no one ever came back to her and asked that she change the "1" to a "4." She stated that it happens often that people come back after their notes have expired and ask that they be changed. She stated that she will not change a work status note. Ms. Connor explained that she tells people that ask their notes to be changed that it is illegal to change the notes and that they will have to be seen by the doctor again if they want a new note.

Ms. Connor verified again that the discharge sheet noting return to work on September 1, 2008, was completed by the doctor, and that she would have prepared the work status note based on that discharge sheet. She testified that it is her belief that when she made the work status note, it said something other than "9/4/08."

On cross-examination Ms. Connor testified that because Dr. Ross filled in a specific date for return-to-work, she would not have filled in something different on the work status note. She stated that Dr. Ross often leaves the return-to-work portion blank, and in those cases she may use her discretion if the patient asks for a work excuse. Ms. Connor testified that she does not recall having any conversation with the claimant about which day she would be going back to work.

Ms. Connor was asked to write out the numerals "1" through "10" for observation. She pointed out that in her normal script the number "4" is written differently than as on the work status note in evidence. Ms. Connor's numerals written in the deposition show the number "4" written in an open-top fashion, while it is closed at the top on the work status note.

Ms. Connor went on to verify the complete records from the claimant's ER visit. She explained that the CNA would have taken the claimant's vital signs immediately prior to discharge. She also stated that the notes indicate that the claimant ambulated from the ER. Ms. Connor stated that they do not usually take patients to their cars in wheelchairs unless there is some specific reason to do so. She confirmed that the notes indicated that the claimant walked out of the ER on her own. Ms. Connor testified that she would have instructed the CNA to take the claimant's vital signs just prior to discharge. Then, Ms. Connor would have handled the actual discharge process.

Ms. Connor testified that when she received the notice of deposition, she looked in the ER log book to try and remember her treatment of the claimant. She stated that she spoke to Dr, Cantey at the hospital about the fact that she was being deposed. She also called the nursing facility to see what the deposition was about, but she left a message and no one ever called her back.

Ms. Conner testified that the ER does not make a copy of the work excuses which are given. She stated that most people don't ask for work excuses, so they just don't bother giving them. She stated that she filled out a work excuse in this case because the doctor happened to include a return-to-work date in his notes. She does not recall the claimant specifically asking for a work note. Ms. Connor stated that she would not have changed the date on the work status note if the claimant told her that the claimant was not scheduled to work again until the 4th. Ms. Connor stated that it was not her choice as to the return to work date, and that it wouldn't matter if the claimant was not scheduled to work on the date indicated for ability to return. She noted that return to work dates was merely meant to show whether the injury was preventing a patient from working.

Based on the evidence presented at the hearing, the Hearing Commissioner made, and the Full Commission adopted, in full, the following:

FINDINGS OF FACT

1. That all parties to this proceeding are bound by and subject to the terms and provisions of the South Carolina Workers' Compensation Act, as amended to date, with Ridgeway Health and Rehab as the employer, The Phoenix Insurance Company as its carrier, and the claimant as the employee of the employer.

2. That the claimant's average weekly wage is four hundred seventy-nine and 86/100 dollars ($479.86), yielding a compensation rate of three hundred nineteen and 92/100 dollars ($319.92).

3. That, based upon the admissions of the parties, the claimant is still under the care of Dr. Roger Gaddy and is entitled to return to Dr. Gaddy for continued treatment.

4. That, based upon the evidence in the record and the testimony at the hearing, the claimant, or someone on her behalf, falsified the work excuse from Fairfield Memorial Hospital Emergency Department.

5. That, based upon the evidence in the record and the testimony at the hearing, by falsifying the work excuse and by the claimant's subsequent behavior in her insufficient contact with the employer, the claimant was refusing suitable employment.

6. That, based upon the evidence in the record and the testimony at the hearing, the claimant's absence from work was not occasioned by her injury.

7. That, because of the foregoing findings, the claimant is not entitled to temporary total disability compensation.

8. That, based on the evidence in the record and the testimony at the hearing, the claimant could return to full duty work on January 13, 2009.

SUPPLEMENTAL FINDINGS OF FACT

Subsequent to Claimant's appeal to the S.C. Court of Appeals, and in response to the Court of Appeals' order, the Full Commission adds the following:

9. Claimant was disabled under the meaning of the Act from August 31, 2008 until September 1, 2008, when she was placed on light duty status. She was returned to full duty work status by the authorized treating physician, Dr. Gaddy, on January 13, 2009.

10. Claimant refused suitable employment as of September 1, 2008, as she altered (or someone on her behalf altered) the out of work statement. This falsifying on the out of work statement amounts to a refusal of suitable employment in this case and continued on as she sought unemployment benefits, rather than employment within her light duty status. Her refusal

of suitable employment ran from September 1, 2008 through January 13, 2009, when she was returned to full duty status.

11. Based on the overwhelming evidence in this case, including the medical reports, APA submissions, and the testimony of Ms. Burr, which we deem credible and persuasive, we find that the claimant is not entitled to temporary total disability benefits as she refused suitable employment by her actions in falsifying the out of work slip, by not seeking suitable employment elsewhere as she tried for unemployment, and by being able to return to full duty work (under any circumstance) as of January 13, 2009.

CONCLUSIONS OF LAW

Accordingly, as provided under the South Carolina Code of Laws, 1976, as amended, §42-17-60 and §1-23-320, it is the determination of this Commissioner that:

1. Under §42-1-130, the claimant was a covered employee at the time of the accident.
2. Under §42-1-140, the defendant/employer was a covered employer at the time of the accident.
3. Under §42-15-20, Notice of the Act was properly given by the claimant.
4. Under §1-23-320, the claimant received proper notice of the hearing.
5. Under §42-9-190, the claimant unreasonably refused suitable modified duty employment provided by the defendant/employer and approved by the authorized treating physician, thus the claimant is not entitled to temporary total disability benefits.

ORDER

NOW, IT IS THEREFORE ORDERED, ADJUDGED, AND DECREED that the claimant is not entitled to temporary total disability benefits because her actions following her

accident amounted to unreasonable refusal of suitable light duty employment offered by the defendant/employer.

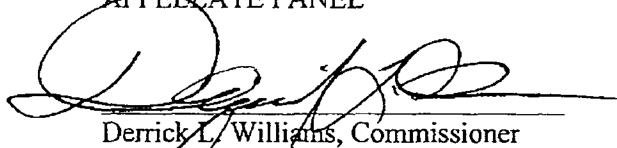
IT IS FURTHER ORDERED that the claimant has not yet been released from the care of Dr. Roger Gaddy and is entitled to return for further treatment.

ORDER OF THE APPELLATE PANEL

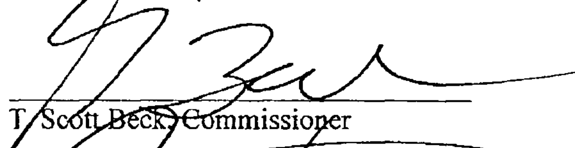
IT IS HEREBY ORDERED, ADJUDED, AND DECREED that, based on review of the record as a whole and the oral arguments of the parties made before the Appellate Panel, the Appellate Panel adopts the findings and conclusions of the Hearing Commissioner verbatim, and in their entirety. The Appellate Panel hereby affirms the Hearing Commissioner's decision and order as to all issues.

IT IS SO ORDERED.

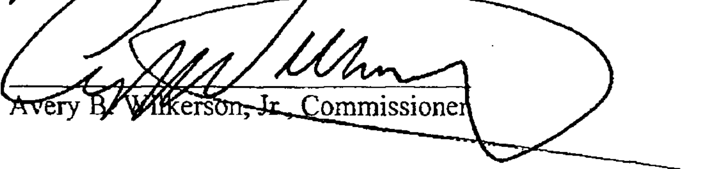
SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION
APPELLATE PANEL



Derrick L. Williams, Commissioner



T. Scott Beck, Commissioner



Avery B. Wilkerson, Jr., Commissioner

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United State mail, addressed to the attorney or attorneys for said parties.
This 27 day of August, 2012
By ____________
Administrative Assistant to the Commissioner

R. Daniel Addison
Preston F McDaniel

8/27, 2012