THE WEST VIRGINIA PUBLIC EMPLOYEES
GRIEVANCE BOARD

JAY HARMAN BAGWELL,
Grievant,

v. **Docket No. 2009-1549-MAPS**

DIVISION OF VETERAN'S AFFAIRS
Respondent.

DECISION

Jay Harman Bagwell, Grievant, was employed as a Licensed Practicing Nurse for the Division of Veteran's Affairs at the West Virginia Veterans Nursing Facility in Clarksburg, West Virginia. This grievance was filed at level one on or about May 20, 2009, contesting the termination of Grievant's employment. The Statement of Grievance asserts an "improper investigation involving improper standard of care on 4/17/09, WVVNF not being able to make correct wage payment, WVVNF not properly training of staff, barred from visitation or phone calls to WVVNF." Grievant seeks as relief the "full and complete investigation into incident of 4/17/09, to be pay [sic] in full money due to me, changes to be made concerning training of staff, right to visitation and phone call by this LPN restored."

This grievance was denied at level one by letter dated June 8, 2009, from the Respondent's designee and Deputy Director, Mike Lyons. The grievance was mediated on September 14, 2009, at the Grievance Board's Westover office location. The parties had agreed on terms for a possible settlement but requested that the Board hold the matter in abeyance in order to allow for finalization of the terms of the settlement. Grievant appealed to level three of the grievance procedure on December 3, 2009. A level three

hearing was conducted before the undersigned Administrative Law Judge on January 27, 2010, at the Grievance Board's Westover office. Grievant appeared and represented himself. Respondent appeared by its counsel, Nicole A. Cofer, Assistant Attorney General. This matter became mature for consideration upon receipt of the last of the parties' fact/law proposals on March 8, 2010.

Synopsis

On April 17, 2009, Grievant was responsible for attending to a resident returning from having a surgical procedure at the Veterans Administration Hospital which required numbing of the resident's throat. The proper standard of care for a nurse charged with caring for a resident who is returning from a surgical procedure includes, among other requirements, a physical assessment of the resident. This would be accomplished by visually observing the resident's body for any changes upon his or her return, taking vital signs, and documenting the assessment.

The resident returned from the Veterans Administration Hospital to the Grievant's wing with an unnoticed and undocumented intravenous fluid drip which should have been noted on the patient's chart. Grievant admitted that he did not document any assessment of the resident, nor did he document any of his alleged actions in the resident's chart. Respondent proved the charges against Grievant and established he was dismissed for good cause. While not entirely relevant to a discussion of his dismissal, his other concerns relating to training, wages, and visitation of residents have been addressed by Respondent during the grievance proceedings.

The following findings of fact are based upon a thorough review of the entire record of this grievance.

Findings of Fact

1. Grievant has been practicing as a Licensed Practicing Nurse ("LPN") for six years and was employed as a LPN at the West Virginia Veterans Nursing Facility.

2. On April 17, 2009 around 4:00 p.m., a resident from the Veterans Nursing Facility returned from having a surgical procedure at the Veterans Administration Hospital which required numbing of the resident's throat.

3. The resident in question was among the residents that Grievant was responsible for attending to during his shift.

4. Performing and documenting a physical assessment of a resident who is leaving or returning from a surgical procedure at the Veterans Administration Hospital is common practice and the proper standard of care for a nurse to ensure that the resident's condition is stable. Margie Brown, Registered Nurse, Respondent's Director of Nursing, level three testimony.

5. The resident returned from the Veterans Administration Hospital to Grievant's wing with an unnoticed and undocumented intravenous fluid drip ("IV").

6. A physical assessment of the resident would have identified that an IV was present, and assured such information would be passed along to the proper health care provider to handle.

7. Grievant admitted that he did not document any assessment of the resident, and at no time during Grievant's shift did he document in the resident's chart the presence of an IV.

8. Because of the failure to physically assess the resident there existed a three to four-hour period between the resident's return to the Nursing Facility and the discovery of the resident's IV during which the resident's well being was at risk.

9. Grievant alleges that he instructed a Health Service Worker on staff during his shift to take the vital signs of the returning resident; however, there was no documentation of those vital signs in the resident's chart and Grievant acknowledged that he did not follow up with the Health Service Worker to confirm that the vital signs had been taken.

10. Margie Brown, Registered Nurse and Respondent's Director of Nursing, investigated the allegation of neglect against the Grievant. Ms. Brown then reported her findings to Dr. Kevin Crickard, Administrator of the West Virginia Veterans Nursing Facility, with her opinion on the issue of whether or not Grievant's conduct constituted gross neglect of a resident.

11. By letter dated May 4, 2009, Dr. Crickard advised Grievant that he was terminated from his employment at the facility for gross neglect of a resident of the Veterans Nursing Facility.

12. Grievant had several other documented disciplinary actions during his employment with Respondent. Grievant received a final written warning for sleeping on duty in October 2008. Grievant was also counseled for excessive absenteeism in January 2009. Grievant received a written warning for unsatisfactory work performance for inaccurately following a physician's diet order in February 2009.

Discussion

The burden of proof in disciplinary matters rests with the employer, and the employer must meet that burden by proving the charges against an employee by a preponderance of the evidence. Procedural Rules of the W. Va. Public Employees Grievance Bd. 156 C.S.R. 1 § 3 (2008); *Holly v. Logan County Bd. of Educ.*, Docket No. 96-23-174 (Apr. 30, 1997); *Hanshaw v. McDowell County Bd. of Educ.*, Docket No. 33-88-130 (Aug. 19, 1988). "A preponderance of the evidence is evidence of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not." *Petry v. Kanawha County Bd. of Educ.*, Docket No. 96-20-380 (Mar. 18, 1997). In other words, "[t]he preponderance standard generally requires proof that a reasonable person would accept as sufficient that a contested fact is more likely true than not." *Leichliter v. W. Va. Dep't of Health & Human Res.*, Docket No. 92-HHR-486 (May 17, 1993).

Permanent state employees who are in the classified service can only be dismissed for "good cause," meaning "misconduct of a substantial nature directly affecting the rights and interest of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention." Syl. Pt. 1, *Oakes v. W. Va. Dep't of Finance and Admin.*, 164 W. Va. 384, 264 S.E.2d 151 (1980); *Guine v. Civil Serv. Comm'n*, 149 W. Va. 461, 141 S.E.2d 364 (1965).

Grievant was notified by Dr. Kevin Crickard, Nursing Facility Administrator, by correspondence dated May 4, 2009, of his dismissal. This correspondence provided, in pertinent part, the following:

> You are aware of the identity of the resident at issue, though (to ensure his privacy) he will not be identified here by name. You claimed to have seen the resident shortly after arrival from the VA Hospital, and you claimed to be working on obtaining the resident's discharge orders. Conversely, you admitted that you failed to assess the resident. Neither the medical chart nor the statements of nurses who worked that evening substantiated your claim of seeing the resident or obtaining discharge orders. The Director of Nursing has searched the medical chart, and there are no signed discharge orders in the time period of the incident. Additionally, Robin Goff, LPN has no knowledge of your conversations where she was allegedly working with you to obtain the discharge orders. In fact, she clearly objected to your inability to assess the resident on the next day's shift.
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> Furthermore, by your own admissions and the statements of these nurses, you were unaware several hours after the resident's return from surgery that the resident had an I.V. Especially after a return from an operation, there is a standard of care to assess the resident to ensure that his condition is stable. You failed to meet this standard. Brenda Coleman, RN, stated upon arrival on her shift between 6:30 p.m. - 7:30 p.m. she asked you about the I.V. and you said, "He has an I.V.?" This occurred at least two hours after the resident's return from the hospital. As a result of your failure to assess a resident's condition upon return from an invasive surgery, there was a three to four hour period where the resident's health and safety were at risk.
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> On April 30, 2009, Margie Brown and I held a discussion with you regarding the nature of your negligent conduct. At that time it was shared with you that your dismissal from employment was being considered. You responded by understanding that you had made a mistake stating that, "you had endangered lives", [sic] but that you hope to still have a future here. After considering your response and having considered all the information made known to me, I have concluded that your dismissal is warranted.

In the instant grievance, Respondent has met its burden of proving that Grievant's conduct was of a substantial nature directly affecting the rights and interest of the resident in question at Respondent's facility. Grievant had the ultimate responsibility for the resident for the day and he was neglectful in his care of this resident. Grievant neglected to assess and document on a resident that had returned from day surgery. Grievant admitted to his immediate supervisor that he was aware that the resident returned to the

facility at 1600 or 4:00 p.m. Nevertheless, Grievant did not physically observe the resident to assess him post surgery until the supervising registered nurse was making rounds and noted an IV on the resident.

Mrs. Brown notes in her investigative report that "[t]his was a post-op IV that was to be discontinued as soon as returning to the facility. Grievant's neglect to assess the resident placed the resident at a very high risk for injury or death. The resident had day surgery which required his throat to be numbed. This in itself posed a bleeding and choking risk to the resident. Jay left the resident without any nursing supervision from 1600-1930 when the nursing supervisor discovered the resident had returned. Along with not assessing or monitoring the resident upon return, Jay did not document the resident's departure or return from surgery. This incident is reportable to the board of nursing for neglect. I feel that Jay is a danger to residents due to his continued inability to make appropriate nursing decisions based on basic nursing principles. He continues to have poor judgment that places our residents at risk. Thankfully, no poor outcomes have resulted." Respondent's Exhibit 1, level three.

After due consideration of the extensive testimony at level three, as well as Grievant's admission of his failure to assess a post-operative resident upon that resident's return to the facility, and the admission that he did not make any record in the resident's chart regarding the time of the resident's departure and return, the undersigned finds by a preponderance of the evidence that Respondent has proven its charge of neglect.

As there are other issues raised in this grievance, normally each issue would be addressed in turn. However, given Grievant's dismissal is being upheld by the

undersigned, the issues of training and visitation or phone calls with residents are moot.[1] "Relief which entails declarations that one party or the other was right or wrong, but provides no substantive, practical consequences for either party, is illusory, and unavailable from the [Grievance Board]." *Miraglia v. Ohio County Bd. of Educ.*, Docket No. 92-35-270 (Feb. 19, 1993). "Moot questions or abstract propositions, the decisions of which would avail nothing in the determination of controverted rights of persons or property, are not properly cognizable [issues]." *Bragg v. Dep't of Health & Human Res.*, Docket No. 03-HHR-348 (May 28, 2004); *Burkhammer v. Dep't of Health & Human Res.*, Docket No. 03-HHR-073 (May 30, 2003).

Finally, concerning the pay assertion as listed in the Statement of Grievance, Grievant submitted exhibits at level three taking issue with payment or nonpayment for a BrickStreet claim resulting from an injury he sustained on or about March 7, 2009. The undersigned has no jurisdiction over any dispute concerning a worker's compensation claim. "An administrative agency is but a creature of statute, and has no greater authority than conferred under the governing statutes." *Monongahela Power Co. v. Chief, Office of Water Res., Div. of Envtl. Prot.*, 211 W. Va. 619, 567 S.E.2d 629, 637 (2002). Consequently, the jurisdiction of the Public Employees Grievance Board is limited to the grant of authority provided in WEST VIRGINIA CODE §§ 6C-2-1 *et seq*.

The following conclusions of law support the decision reached.

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[1]Grievant indicated at level three that he was pleased with the changes made in the training of LPNs at the facility and no longer takes issue with this in his grievance. Likewise, he acknowledged that he had been granted permission to visit residents at the facility during regular hours.

Conclusions of Law

1. The burden of proof in disciplinary matters rests with the employer, and the employer must meet that burden by proving the charges against an employee by a preponderance of the evidence. Procedural Rules of the W. Va. Public Employees Grievance Bd. 156 C.S.R. 1 § 3 (2008); *Holly v. Logan County Bd. of Educ.*, Docket No. 96-23-174 (Apr. 30, 1997); *Hanshaw v. McDowell County Bd. of Educ.*, Docket No. 33-88-130 (Aug. 19, 1988).

2. Permanent state employees who are in the classified service can only be dismissed for "good cause," meaning "misconduct of a substantial nature directly affecting the rights and interest of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention." Syl. Pt. 1, *Oakes v. W. Va. Dep't of Finance and Admin.*, 164 W. Va. 384, 264 S.E.2d 151 (1980); *Guine v. Civil Serv. Comm'n*, 149 W. Va. 461, 141 S.E.2d 364 (1965).

3. Respondent has met its burden of proving that Grievant's conduct was of a substantial nature directly affecting the rights and interest of the resident in question at Respondent's facility. Grievant was dismissed for good cause.

Accordingly, this grievance is **DENIED**.

Any party may appeal this Decision to the Circuit Court of Kanawha County. Any such appeal must be filed within thirty (30) days of receipt of this Decision. *See* W. VA. CODE § 6C-2-5. Neither the West Virginia Public Employees Grievance Board nor any of its Administrative Law Judges is a party to such appeal and should not be so named. However, the appealing party is required by W. VA. CODE § 29A-5-4(b) to serve a copy of

the appeal petition upon the Grievance Board. The Civil Action number should be included so that the certified record can be properly filed with the circuit court. *See also* 156 C.S.R. 1 § 6.20 (eff. July 7, 2008).

Date: May 7, 2010

Ronald L. Reece
Administrative Law Judge