WEST VIRGINIA PUBLIC EMPLOYEES GRIEVANCE BOARD

REBECCA D. FORREN,
Grievant,

v. **Docket No. 2012-0495-DHHR**

DEPARTMENT OF HEALTH
AND HUMAN RESOURCES/
JACKIE WITHROW HOSPITAL,
Respondent.

DECISION

Grievant, Rebecca Forren, was employed by the Respondent, Department of Health and Human Resources ("DHHR"). She worked as a Health Service Worker in the Jackie Withrow Hospital ("Hospital") located in Beckley, West Virginia. By letter dated November 1, 2011, Grievant Forren's employment at the Hospital was terminated. Ms. Forren filed a level three grievance form[1] dated November 4, 2011, alleging that her employment was terminated without good cause. Grievant seeks, "To be made whole including lost wages with interest & benefits restored."

A level three hearing was held in Beckley, West Virginia on April 27, 2012. Grievant appeared at the hearing and was represented by Gordon Simmons, Steward, UE Local 170, West Virginia Public Workers Union. Respondent was represented by Michael E. Bevers, Assistant Attorney General. The parties submitted written Proposed Findings of Fact and Conclusions of Law, the last of which was received by the West Virginia Public Employees Grievance Board on June 4, 2012. This matter became mature for decision on that date.

[1] W. VA. CODE §6C-2-4(a)(4) authorizes an employee contesting the termination of her employment to file an expedited grievance directly at level three.

Synopsis

Grievant was dismissed for allegedly placing a resident in a restraining chair and confining another resident to her room, both without proper authorization. She was also charged with violating a resident's right to be treated with dignity by removing a male resident's gown in the hallway, in the presence of other residents and staff, so that the gown could be adjusted. Grievant denied two of the allegations. Grievant alleged that she placed one resident in a feeding chair to prevent a confrontation with another resident. She argued that was not a restraint because the resident was able to free herself from the chair. She alleged that the second resident was not confined to her room and was actually in the hall during the evening. Respondent proved the charges that led to Grievant's dismissal and the grievance is DENIED.

After a careful review of the entire record, the following facts were proven by a preponderance of the evidence.

Findings of Fact

1. Grievant, Rebecca Forren, was employed as a Health Service Worker[2] at Jackie Withrow Hospital for approximately six or seven years before her employment was terminated. She was a regular full-time employee of the Respondent.

2. On October 14, 2012, Grievant was working an evening shift at the hospital in a "lock down" unit.[3] Many of the residents in this unit suffer from various forms of dementia and present a risk of leaving the facility. Consequently, the exits to the unit are locked and residents cannot leave without assistance from a staff member.

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[2] Grievant and other Health Services Workers at the Hospital are also referred to as Certified Nursing Assistants.

[3] This term was used by the Hospital employees who testified at the level three hearing.

3. The hallways of the unit are monitored with video cameras. Video clips from the evening of October 14, 2011, were introduced into evidence. These clips showed staff and residents interacting.[4]

4. Resident H.R.[5] suffers from dementia and tends to wander throughout the unit and often tries to leave. Around 7:00 p.m. Grievant Forren escorted H.R. to her room and placed a chair outside the door.

5. Christa McKinney was working in the unit as a Monitor[6] on that evening. Grievant instructed Ms. McKinney to sit in the chair outside H.R.'s room and to keep H.R. in her room. At least once during the evening, H.R. started to come out of her room and Ms. McKinney asked her to go back to bed. H.R. complied.

6. Another Health Service Worker, Kimberly Prince, replaced Ms. McKinney in the chair while Ms. McKinney took a scheduled break. During that time, H.R. again came out of her room and Ms. Prince told her to sit in the chair. H.R. complied and Ms. Prince watched her from across the hall.

7. At around 8:42 p.m., H.R. was standing outside her room and drinking from a cup. Grievant approached H.R. and pushed her elbow up in a way that appeared as if she was forcing H.R. to drink more quickly. Grievant then escorted H.R. back into her room.

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[4] When specific times are referred to herein, they are confirmed from the video clips. The actual video has been admitted into the record but is ordered sealed and is only to be viewed by court officials if this decision is appealed.

[5] Hospital residents will be identified herein by initials to protect their privacy. It is not necessary to reveal their identity to fully address the issues in this matter.

[6] Monitors assist the staff in getting food and clothing for the residents. They are subordinate to Health Service Workers and are not responsible for direct resident care.

8. There was no doctor order or medical reason for H.R. to be confined to her room or to have one-on-one care.[7]

9. Shortly after 9:00 p.m., there was a disturbance in the room of resident J.B. That resident was having an argument with her roommate over which bed belonged to which resident. Grievant Forren, Ms. McKinney and Ms. Prince went into J.B.'s room to settle the dispute.

10. A Licensed Practical Nurse ("LPN"), Robin Darby Black, was working at the nursing station in the unit. At approximately 9:30 p.m., Grievant escorted J.B. down the hall to the dining room. As she passed LPN Black, Grievant said that she was taking J.B. to "the chair."

11. Grievant took J.B. to the dining room and placed her in a restraining chair with a snack. This chair has arms along the sides. A tray slides on to the arms and locks in place, confining the resident to the chair. The release level is located on the front of the tray and most residents cannot reach the lever to free themselves.

12. Grievant placed J.B. in the chair to separate her from her roommate so that the dispute between the two residents would calm down. J. B. was escorted back to her room by Grievant at approximately 11:00 p.m.

13. Approximately fifteen minutes after Grievant had placed J.B. in the restraining chair, LPN Black went to the dining room to check on her and noticed that J.B. was eating a snack and seemed content. Later, Ms. McKinney was passing

[7] During the testimony, it was explained that one-on-one care at the Hospital occurs when one staff person is assigned to monitor a single resident. Unlike in psychiatric hospitals, the staff person may be posted outside the resident's room and does not have to keep the resident in her line of sight.

through the dining room and saw J.B. sitting in the restraining chair. J.B. did not seem to be in distress.

14. There was no doctor order or medical reason for J.B. to be confined to the chair as a restraint.

15. At 10:12 p.m. an elderly male resident, L.P., was standing in the hallway near the nurse's station. Female resident, H.R., was sitting in the chair outside her room and could see L.P. There were also female staff members in the hall. Two female monitors were adjusting L.P.'s gown which was falling off his shoulder. Grievant approached resident L.P., untied his gown, and let it drop to the floor. At that point, L.P. was dressed only in underpants. Grievant then placed a different gown on L.P. and tied it in place. L.P. did not overtly react to this activity.

16. Any allegation of resident abuse or neglect of a resident by a Health Service Worker, who are employed as Certified Nursing Assistant, must be reported to the Office of Health Facility Licensure and Certification ("OHFLAC").

17. By form dated October 18, 2011, the Hospital Director of Nursing, Carla Lewis, reported to OHFLAC that Grievant was accused of abuse or neglect of H.R. by causing her to be confined to her room without medical authorization. Respondent's Exhibit 4.

18. By form dated October 27, 2011, the Hospital Chief Executive Officer ("CEO") Angela Booker, reported to OHFLAC that Grievant was accused of abuse or neglect of J.B. by placing her in an restraining chair for an hour and a half without a doctor's order. Respondent's Exhibit 7.

19. By form dated October 27, 2011, the Hospital Nurse Unit Director, Sheila Murphy, reported to OHFLAC that Grievant was accused of abuse or neglect of L.P. by changing his gown in the hall in view of staff and residents, thereby failing to provide L.P. with privacy. Respondent's Exhibit 8.

20. After conducting an investigation into the allegations of resident abuse, CEO Booker determined that the allegations were substantiated. She met with Grievant, told her of the allegations and allowed Grievant the opportunity to address them. By letter dated November 1, 2011, Grievant's employment was terminated. Respondent's Exhibit 22.

21. Grievant had previously been placed on a Performance Improvement Plan for poor attendance. On August 3, 2011, Grievant was suspended for three days without pay for failing to comply with the plan. Respondent's Exhibit 19. On October 7, 2011, Grievant was suspended for five days without pay for "continued failure to adhere to the Performance Improvement Plan. Respondent's Exhibit 20.

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 Board, 156 C.S.R. 1 § 3 (2008); *Ramey v. W. Va. Dep't of Health*, Docket No. H-88-005 (Dec. 6, 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). Where the evidence equally supports both sides, the employer has not met its burden. *Leichliter v. W. Va. Dep't of Health & Human Res.*, Docket No. 92-HHR-486 (May 17, 1993).

Grievant was a permanent state employee in the classified service. 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). *See also Sloan v. Dep't of Health & Human Res.*, 215 W. Va. 657, 661, 600 S.E.2d 554, 558 (2004) (per curiam).

Respondent alleges that Grievant violated important rights of residents in her care by improperly restricting one to her room, placing one in restraint for an hour and a half and disrobing one in the hallway. Grievant counters that these actions were taken for the benefit the residents. She placed J.B. in the restraining chair to keep her away from her roommate until their tempers cooled. She denies that she confined H.R. to her room and points to the fact that she was seen in the hall throughout the night. Finally, Grievant argues that there was no evidence introduced to indicate that Grievant knew that H.R. was in the hall when Grievant removed L.B.'s gown.

The standards for resident care in long-term care facilities are set by federal and state rules and regulations. The Code of State Rules, defines "abuse" as:

> The willful infliction of injury, unreasonable confinement, intimidation, or, punishment, which results in pain, mental anguish or harm, even if the resident is unaware the harm has occurred.

W. VA. CODE ST. R. § 69-6-2.1

That section of the rule additionally defines "involuntary seclusion" as:

> Separation of a resident from other residents or from his or her room, or confinement to his or her room (with or without roommates), against the resident's will, or the will of the resident's legal representative. Emergency or short-term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

W. VA. CODE ST. R. § 69-6-2.1a

The Code of Federal Regulations at 42 C.F.R.§ 485 sets out requirements for state and long-term care facilities. The section related to "resident behavior and facility practices" provides the following with regard to restraining residents:

> (a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
>
> (b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

42 C.F.R. § 485.13. The federal regulations also provide:

> (a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

42 C.F.R. § 485.15.

Respondent proved that Grievant violated these requirements. She placed J.B. in a restraining chair to defuse the argument with J.B.'s roommate. She could have

separated the residents without restraining J.B. Even if the restraint was justified for a short time, there was clearly no justification for leaving J.B. restrained for nearly ninety minutes. The fact that J.B. seemed content in the restraint does not excuse this action.

Likewise, Grievant escorted H.R. to her room at 7:00 p.m. and placed Ms. McKinney outside H.R.'s room because H.R. "kept trying to get off the unit."[8] Undoubtedly, these residents can be trying to staff, but the unit is locked and H.R. could not get off the unit without help. Placing H.R. in her room at this early hour and asking a monitor to keep her there, clearly violates the rule against involuntary seclusion. The fact that H.R. was occasionally allowed to sit in the chair outside her room does little to mitigate this violation.

Finally, it was unquestionably an affront to L.B.'s dignity to drop his gown in the hallway in front of female staff and a resident. L.B. is an adult male. While he may not have apparent cognition of this event, the public policy established by federal regulations is that he is entitled to at least some dignity and privacy rather than to be dressed and undressed in the hallway like a life-size doll.

Respondent proved the charges by a preponderance of the evidence and discipline was justified. Grievant argued at her predetermination conference that she did not intend to violate these policies and she tried to keep the best interest of the residents in mind. Her actions do not comport with her words. Her willingness to confine residents for what appears to be convenience in care indicates, at best, a rather callous indifference to their rights and dignity. Accordingly, the grievance is DENIED.

[8] Ms. McKinney testified at level three that this was the reason she was given by Grievant Forren for posting her in the chair at H.R.'s door.

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 Board, 156 C.S.R. 1 § 3 (2008); *Ramey v. W. Va. Dep't of Health*, Docket No. H-88-005 (Dec. 6, 1988).

2. Grievant was a permanent state employee in the classified service. 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). *See also Sloan v. Dep't of Health & Human Res.*, 215 W. Va. 657, 661, 600 S.E.2d 554, 558 (2004) (per curiam).

3. Respondent proved by a preponderance of the evidence that Grievant improperly restrained a resident in violation of 42 C.F.R. § 485.13.

4. Respondent proved by a preponderance of the evidence that Grievant improperly subjected a resident to involuntary seclusion in violation of W. VA. CODE ST. R. § 69-6-2.1a.

5. Respondent proved by a preponderance of the evidence that Grievant failed to provide a resident with proper dignity and privacy in violation of 42 C.F.R. § 485.15.

Accordingly, the 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 (2008).

DATE: SEPTEMBER 20, 2012

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WILLIAM B. MCGINLEY
ADMINISTRATIVE LAW JUDGE