THE WEST VIRGINIA PUBLIC EMPLOYEES GRIEVANCE BOARD

LEIGHANNE RULEY,
Grievant,

v. **Docket No. 2019-1633-CONS**

DEPARTMENT OF HEALTH AND HUMAN RESOURCES/MILDRED MITCHELL-BATEMAN HOSPITAL,
Respondent.

DECISION

Grievant, Leighanne Ruley, was employed by Respondent, Department of Health and Human Resources ("DHHR"). She was assigned to Mildred Mitchell-Bateman Hospital ("MMBH") as a Licensed Practical Nurse ("LPN"). Ms. Ruley filed an expedited grievance to level three[1] dated April 11, 2019, alleging that she was suspended without good cause.[2] As relief Grievant seeks backpay with interest. Ms. Ruley initiated a second expedited grievance at level three dated May 15, 2019, alleging that she had been dismissed without good cause. She seeks reinstatement to her position as LPN, backpay with interest, and restoration of benefits. The two grievances were consolidated for hearing and decision by an order dated May 24, 2019.

A level three hearing was conducted at the Charleston office of the West Virginia Public Employees Grievance Board via the Zoom video platform, on October 19, 2020. Grievant personally appeared and was represented by Gary DeLuke, UE Local 170. Respondent was represented by Katherine Campbell, Assistant Attorney General. A

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[1] *See* W. VA. CODE § 6C-2-4(a)(4) which allows expedited grievances contesting suspensions and dismissals to be filed initially at level three.
[2] Grievant was suspended pending an investigation into alleged misconduct.

second day of hearing was conducted on December 9, 2020, so the parties could supplement the record with additional exhibits and testimony concerning them. This matter became mature on March 23, 2021, upon receipt of the Grievant's Proposed Findings of Fact and Conclusions of Law.[3]

Synopsis

Grievant and three other workers were terminated from employment at MMBH for failing to perform required periodic checks to ensure that patients were in their rooms and not in acute distress. An investigation was conducted and concluded that Grievant and others had committed patient neglect by failing to provide the necessary and required supervision for patients in their care. Grievant was able to show that she performed one "face check" and had traded duties with another employee to perform some others. However, Respondent proved that Grievant failed to perform a required "spot check" and completed the patient check forms at the beginning of the shift rather than as the checks were conducted. This resulted in the appearance that Grievant had conducted "face checks" and a "spot check" which she had not. The grievance is denied.

The following Findings of Fact are based upon a complete and thorough review of the record created in this grievance.

Findings of Fact

1. Grievant, Leighanne Ruley, was employed by Respondent, Department of Health and Human Resources ("DHHR"). She was assigned to Mildred Mitchell-Bateman

[3] Mr. DeLuke left employment with UE 170 at the end of 2020, but he agreed to submit the post hearing filing in this matter. He requested and received a number of extensions for the filing of the proposed findings and conclusions. Respondent requested and received one extension.

Hospital (“MMBH”) as a Licensed Practical Nurse (“LPN”),and held that position for approximately seven years.

2. MMBH is a psychiatric hospital which requires heightened levels of security for its patients.

3. MMBH Policy NURe35, Unit Face Checks/Security Checks, requires that “face checks” be done on each patient every fifteen minutes.

4. The purpose of a face check is to account for the presence and well-being of each patient.

5. The staff member performing the check must visually confirm the location and well-being of each patient. If a patient is in bed the staff member must enter the room and confirm “signs of life.”

6. The performance of face checks is documented on a form. The form covers a twenty-four-hour period beginning at 7:00 a.m., dated that day and continuing until 6:59 a.m. the next day. The form lists each patient by room number. The form has a column for each 15-minute check. (Respondent Exhibit 7)

7. The staff member performing the check is to record the location of each patient, using the provided codes on the form, and initial at the bottom of the column for each time period. The initials are to be filled in as the staff person performs the check to verify that the check was done, and the patient was present and not in distress.

8. On April 3, 2019, Grievant was originally assigned to perform the face checks from 4:15 a.m. through 5:00 a.m. Grievant and the rest of the staff initialed all the spaces on the face check sheet at the beginning of the shift rather than as they performed the face checks to ensure that all the spaces were filled in as required.

9. In addition to the face checks, separate spot checks must be performed every hour by a licensed staff member such as a Licensed Practical Nurse or a Registered Nurse ("RN"). Grievant was assigned to perform a spot check of the patients at 5:00 a.m. She initialed the column for spot checks on the form indicating that she had performed the 5:00 a.m. spot check.[4] Spot checks are recorded on the same form as face checks. (Respondent Exhibit 7)

10. On April 3, 2019, contract staff member Elizabeth McKisic reported to the RN that she was sitting one-on-one with a patient during the period of 4:00 a.m. through 6:00 a.m. Ms. McKisic reported that during that time she observed a female patient leave her room, walk through the hall, and then go into a male patient's room. After a "few minutes" the female patient came out of the male patient's room and returned to her own room. Ms. McKisic told the RN that she had tried unsuccessfully to contact other staff about the problem.

11. As a result of this report a patient grievance was filed alleging:

> On 4-3-19 between the hours of 0400 & 0600 no one did face check on unit 4 and a pt. MS went into a male patient's room for 45 minutes and no one redirected her or saw her in the room.

It was submitted to Adult Protective Services and the Legal Aid of West Virginia (LAWV) patient advocate Teri Stone, MA. She and the MMBH staff investigator, Sherrie Cox, RN performed a parallel investigation of the allegations in the grievance.

[4] Ideally the face check and spot check for a given time should be performed by different staff members but that is not always the case due to staffing issues.

12. The Patient Grievance Form is dated for 4-3-19 and indicates that it was received by the advocate on 4-9-19 at 4:56 p.m. It is signed by the LAWV advocate Teri Stone and dated as resolved on 4-25-19.[5]

13. The grievance form was initiated after an Incident Report and an Adult Protective Services Mandatory Reporting Form were completed by Unit 4 Nurse Manager, Delores Maynard, RN. These forms are dated April 9, 2019.

14. As part of the security for the hospital, there are video cameras situated in every hallway to record patient and staff activity. Advocate Stone and Investigator Cox reviewed the video tapes in Unit 4 for the period of 4:00 a.m. through 6:00 a.m. on April 3, 2019.

15. The video surveillance tapes revealed that on April 3, 2019, at 5:01 a.m., a female patient, M.S., entered the room of a male patient where she remained for forty-five minutes. The video surveillance shows Grievant around 4:30 a.m. finishing the face checks she began around 4:15 a.m. No other face checks were performed during the two-hour period.

16. The video tapes also revealed that M.S. came to the door of the room where Ms. McKisic was stationed one-on-one with a patient. The patient spoke briefly with Ms. McKisic before walking to the male patient's room and entering. Ms. McKisic did not make any apparent effort to contact the other staff regarding M.S. entering a male patient's room and remaining there.

17. In addition to face checks, staff are assigned to remain with particularly difficult patients on a one-on-one basis. When serving those assignments, the staff must

[5] *See* Respondent Exhibit 2.

stay in the patient's room and continuously observe them. An observation record is kept of those assignments. The staff member must fill in the sheet every five minutes noting the patient, his/her activity, and initial the note. [6]

18. On April 3, 2019, Health Service Worker ("HSW"), Debra Sparks was assigned to be one-on-one with a particular patient from 3:45 a.m. through 5:00 a.m. She filled in the Observation Record every five minutes during that period and initialed it every five minutes. On the form, her initials are written over at 4:40 a.m., 4:45 a.m., 4:50 a.m., 4:55 a.m., and 5:00 a.m. The new initials appear to be Grievants. Additionally, the activity "Bed Resting" is written on all the form except 4:50 a.m., 4:55 a.m. and 5:00 a.m. At those times, the activity is listed as "In bed asleep." The ink used on these entries is much darker that the ink on the rest of the form. (Grievant Exhibit 2)

19. It is more likely than not that Grievant relieved Ms. Sparks at the one-on-one assignment from 4:45 a.m. through 5:00 a.m. because Ms. Sparks was having difficulty staying awake at her post.[7]

20. Grievant was scheduled to perform a spot check at 5:00 a.m. Ms. Sparks was not qualified to do the spot check because she was a Health Service Worker; not an LPN or RN. Grievant did not perform the spot check at 5:00 a.m. yet her initials appear on the face check form as if she had completed the spot check.

21. MMBH policy, MMBHE018 prohibits patient neglect and defines the same as "Any negligent, reckless or intentional failure to meet the needs of a patient, or applicable statutory or regulatory requirements, including but not limited to, **lack of**

[6] This is a completely separate sheet from the face check sheet.
[7] This finding is based upon the testimony of Grievant and Ms. Sparks as well as the anomalous entries on the Observation Record.

needed supervision, nutritional deprivation, or failure to implement or update a treatment plan." This is the same definition contained in the Department of Health and Human Resources administrative rule, W.VA. CODE ST. R. § 64-59-3.12 (1995). (Emphasis added)

22. At the conclusion of their investigation, Terri Stone, MA, LAWV, and Sherrie Cox, RN, MMBH Staff Investigator, substantiated the allegation of patient neglect based on the face check forms and the surveillance video evidence. In addition to Grievant, neglect was substantiated for one other staff member and a contract worker who had certified that face checks had been completed, and against a contract worker who saw M.S. out of bed and entering the other patient's room and did not alert anyone.[8] (Respondent Exhibit 2)

23. By letter dated May 8, 2019, Grievant was dismissed from employment at MMBH as a result of the substantiated Legal Aide investigation which found that she did not complete face check rounds as assigned even though she documented that her face checks and spot check had been completed between 4:00 a.m. and 5:00 a.m.[9] (Respondent Exhibit 15)

[8] Both staff members were dismissed, and the contract workers were not allowed to return to MMBH. These were all the staff assigned to Unit 4 during the designated shift.

[9] Neither the Investigative Report nor the letter of termination differentiated between "face checks" and "spot checks." Since they are both required supervision activities, both are on the same form, and both require the staff to initial the form when they are completed, it is apparent that term "face check" was used to include both activities.

24. Grievant had been suspended for three days in January 2017 for failure to strictly adhere to the MMBH Medication Administration Policy[10] and for three days in March 2017 for issues relating to attendance and properly clocking in and out.[11]

Discussion

As this grievance involves a disciplinary matter, Respondent bears the burden of establishing the charges by a preponderance of the evidence. Procedural Rules of the W. Va. Public Employees Grievance Bd. 156 C.S.R. 1 § 3 (2018).

> . . . *See* [*Watkins v. McDowell County Bd. of Educ.,* 229 W.Va. 500, 729 S.E.2d 822] at 833 (The applicable standard of proof in a grievance proceeding is preponderance of the evidence.); *Darby v. Kanawha County Board of Education,* 227 W.Va. 525, 530, 711 S.E.2d 595, 600 (2011) (The order of the hearing examiner properly stated that, in disciplinary matters, the employer bears the burden of establishing the charges by a preponderance of the evidence.). *See also Hovermale v. Berkeley Springs Moose Lodge,* 165 W.Va. 689, 697 n. 4, 271 S.E.2d 335, 341 n. 4 (1980) ("Proof by a preponderance of the evidence requires only that a party satisfy the court or jury by sufficient evidence that the existence of a fact is more probable or likely than its nonexistence."). . .

W. Va. Dep't of Trans., Div. of Highways v. Litten, No. 12-0287 (W.Va. Supreme Court, June 5, 2013) (memorandum decision). Where the evidence equally supports both sides, a party has not met its burden of proof. *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

[10] Respondent Exhibit 10.
[11] Respondent Exhibit 11.

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* W. VA. CODE ST. R. § 143-1-12.2.a. (2016). "'Good cause' for dismissal will be found when an employee's conduct shows a gross disregard for professional responsibilities or the public safety." *Drown v. W. Va. Civil Serv. Comm'n*, 180 W. Va. 143, 145, 375 S.E.2d 775, 777 (1988) (*per curiam*).

Grievant argues that she performed one face check at 4:15 a.m. and was not required to perform the remaining face checks because she had relieved HSW Sparks on her one-on-one duties because Ms. Sparks was having trouble staying awake. Grievant opines that HSW Sparks was responsible for the face checks starting at 4:30 a.m. and ending at 5:00 a.m. The video recording demonstrates that face checks were not done over that period.

The two-hour video[12] did show Grievant conducting face checks around 4:30 a.m. It is more likely than not Grievant was finishing her face checks that she began at 4:15 a.m. Additionally, the one-on-one observation sheet entries indicate that it is more likely than not Grievant covered HSW Sparks' one-on-one duties from 4:40 a.m. through 5:00 a.m. Grievant's testimony is uncontested on these facts and is consistent with the video and documentary evidence. However, that does not absolve Grievant of all misconduct.

Without doubt, no one performed the face checks for 4:30 a.m., 4:45 a.m. and 5:00 a.m. yet Grievant initialed the face check documentation sheet indicating that she

[12] Respondent Exhibit 1.

had performed those face checks. Even if she traded duties with Ms. Sparks during that time, she falsified the face check documentation at the very least. More importantly, Grievant did not perform a spot check at 5:00 a.m. which she was assigned to do. Yet her initials appear on the face check form as if she had completed the spot check. As noted above, a HSW is not qualified to perform that spot check for Grievant. Had Grievant conducted her spot check as required she would most likely have discovered M.S. was not in her room. It is even likely that she could have intercepted M.S. and kept her from entering the room of the male patient.

Patient neglect is defined and prohibited by both the administrative rule and MMBH policy. It requires proper supervision of the patients to keep them safe. Grievant's failure to perform her required spot check as well as falsifying of the record confirming face checks and the spot check, violates the duty of supervision and is patient neglect. Grievant had been trained and understood her duties, chose not to perform them, and falsified the record stating she did perform them. Grievant's misconduct contributed to the general failure of supervision on the shift which led to potential serious harm to patient M.S. This is not a simple mistake but substantial misconduct. Respondent proved the reasons for terminating Grievant's employment by a preponderance of the evidence. Accordingly, the grievance is **DENIED.**

Conclusions of Law

1. As this grievance involves a disciplinary matter, Respondent bears the burden of establishing the charges by a preponderance of the evidence. Procedural Rules of the W. Va. Public Employees Grievance Bd. 156 C.S.R. 1 § 3 (2018).

> . . . *See* [*Watkins v. McDowell County Bd. of Educ.,* 229 W.Va. 500, 729 S.E.2d 822] at 833 (The applicable standard of proof

> in a grievance proceeding is preponderance of the evidence.); *Darby v. Kanawha County Board of Education,* 227 W.Va. 525, 530, 711 S.E.2d 595, 600 (2011) (The order of the hearing examiner properly stated that, in disciplinary matters, the employer bears the burden of establishing the charges by a preponderance of the evidence.). *See also Hovermale v. Berkeley Springs Moose Lodge,* 165 W.Va. 689, 697 n. 4, 271 S.E.2d 335, 341 n. 4 (1980) ("Proof by a preponderance of the evidence requires only that a party satisfy the court or jury by sufficient evidence that the existence of a fact is more probable or likely than its nonexistence."). . .

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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* W. VA. CODE ST. R. § 143-1-12.2.a. (2016). "'Good cause' for dismissal will be found when an employee's conduct shows a gross disregard for professional responsibilities or the public safety." *Drown v. W. Va. Civil Serv. Comm'n*, 180 W. Va. 143, 145, 375 S.E.2d 775, 777 (1988) (*per curiam*).

3. MMBH policy, MMBHE018 prohibits patient neglect and defines the same as "Any negligent, reckless or intentional failure to meet the needs of a patient, or

applicable statutory or regulatory requirements, including but not limited to, lack of needed supervision, nutritional deprivation, or failure to implement or update a treatment plan." This is the same definition contained in the Department of Health and Human Resources administrative rule, W.VA. CODE ST. R. § 64-59-3.12 (1995). (Emphasis added)

4. Respondent proved by a preponderance of the evidence that Grievant was guilty of patient neglect by failing to perform her duty to properly supervise patients and falsifying documents related to that supervision.

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 (2018).

DATE: April 13, 2021

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WILLIAM B. MCGINLEY
ADMINISTRATIVE LAW JUDGE