WEST VIRGINIA PUBLIC EMPLOYEES GRIEVANCE BOARD

SHEILA WILLIAMS,
Grievant,

v. **Docket No. 2011-1720-DHHR**

DEPARTMENT OF HEALTH AND
HUMAN RESOURCES/LAKIN HOSPITAL,
Respondent.

DECISION

Grievant, Sheila Williams, is employed as a Health Service Worker at Lakin Hospital ("Hospital") in Mason County, West Virginia. The Hospital is operated by the Respondent, West Virginia Department of Health and Human Resources ("DHHR"). Grievant Williams was suspended without pay for eighty working hours for allegedly failing to report suspected neglect of residents at the Hospital. Ms. Williams filed a grievance directly to level three[1] dated May 24, 2011, alleging that this suspension was "without good cause." As relief, Grievant seeks "To be made whole, including back pay with interest & benefits restored."

A level three hearing was conducted at the Charleston office of the West Virginia Public Employees Grievance Board on December 6, 2011. Grievant personally appeared with her representative, Gordon Simmons, UE Local 170. Respondent DHHR was represented by Michael E. Bevers, Esquire, Assistant Attorney General. Both parties submitted written Proposed Findings of Fact and Conclusions of Law, the last of which was received at the Grievance Board on January 23, 2012. This matter became mature for

---

[1] W. Va. Code § 6C-2-4(a)(4) provides that grievances contesting suspensions without pay may be brought directly to level three of the statutory grievance process.

decision on that date.

Synopsis

While testifying in a separate grievance hearing, Grievant stated that she believed that the staffing level at the Hospital led to occasional resident neglect. Grievant is required to immediately report suspected cases of neglect. After an investigation Respondent suspended Grievant for failing to immediately report what she believed to be neglect of a resident.

Grievant argues that she had told her supervisors on several occasions that she was having difficulty in providing care for the residents' needs when she was scheduled to work alone. Grievant admits that she didn't use the specific word "neglect" when she reported these problems to her supervisors but alleges that she made them fully aware of the issues and her concerns for resident care. Finally, Grievant alleges that the suspension was actually a reprisal against her for participating in the prior grievance proceeding.

Grievant made her supervisors aware of the problems that she believed constituted resident neglect. Consequently, Respondent failed to prove the charges for her suspension.

The following facts are found to be proven by a preponderance of the evidence based upon an examination of the entire record developed in this matter.

Findings of Fact

1. Grievant, Sheila Williams, has been employed by the DHHR at Lakin Hospital as a Health Service Worker for over two years. Employees in this classifications are also considered to be certified nurse aides and are subject to the requirements of the Nurse

Aide Abuse Registry set out in 69 C.S.R. 6 § 1 et seq. Respondent's Exhibit 15.

2. "Lakin Hospital provides quality nursing long-term care services to West Virginia residents who have special placement needs due to behavioral, developmental and other complex problems, and to whom community health will not or cannot provide these needed services."[2] The vast majority of the residents at the Hospital are elderly and need specialized care around the clock.

3. All employees of the Hospital are required to report to "all known, suspected or possible incidents of abuse, neglect, or other violation of resident rights to the immediate supervisor and/or Resident Advocate immediately."[3]

4. Within the nursing facility setting, the term "neglect" is defined as "failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness unless such action is beyond the Nurse Aide's control." 69 C.S.R. 6 § 2.4.

5. In a memorandum dated July 19, 2010, Twonna Williams, RN Program Manager for the WV Long-Term Nursing Assistant Program, discussed the definition of "neglect" and noted as an example of neglect "Failure to report observed or suspected abuse, neglect or misappropriation of property." Respondent's Exhibit 14.

6. Grievant, and thirty-three other employees, filed a prior grievance asserting that the Hospital needed to regularly schedule more employees to care for residents at the facility. Those grievances were consolidated and styled *Goodnite, et al., v. Dept. of Health*

---

[2] *See:* http://www.wvdhhr.org/bhhf/lakin/.

[3] Respondent's Exhibit 12, Lakin Hospital Policy and Procedure Manual, Section Number: 8000 § III. (D) (1) (c). *See also:* 42 C.F.R. § 483.13(e)(2), cited in Respondent's Exhibit 10; 69 C.S.R. 6 § 3.1.a, Respondent's Exhibit 15; and W. Va. Code § 9-6-9(a).

& Human Res., Docket No. 2011-1536-CONS. A level one hearing was conducted in this consolidated grievance on May 9, 2011, and Grievant Williams testified at that hearing.

7. Lakin Chief Executive Officer, Linda Dailey, represented the Hospital in the *Goodnite et al., supra*, hearing and questioned witnesses. During cross examination at the level one hearing, Grievant was asked if she felt that residents were being neglected as a result of the lack of more than one person working in the wing she was assigned to and Grievant Williams answered that she thought they sometimes were.

8. When asked if she reported when she felt residents were neglected, Grievant Williams responded, "Um-hum. Just complained about not enough help. That's pretty much." After a few more questions Grievant was asked: "[H]ave you ever made an allegation of neglect officially to be reported?" and she replied: "Officially, no."[4]

9. Grievant had told her supervisors that it was very stressful when she worked by herself and that she had to wait long periods of time to turn and lift residents.[5] She was concerned about providing proper care for the residents she was assigned to assist.

10. Following the *Goodnite et al.* hearing, CEO Dailey sought advice from the Office of Health Facilities License & Certification ("OHFLAC") as to how to proceed with what appeared to her to be a failure to report suspected neglect by Grievant. Pursuant to advice she received, CEO Dailey commenced an investigation regarding Grievant's level

---

[4] Level 1 Transcript of *Goodnite et al., supra.*

[5] These procedures are required for residents who are not mobile to prevent skin and fracture problems and require at least two staff members to be properly performed. Grievant noted that she sometimes had to wait as much as forty-five minutes for another person to assist with these tasks. She remained busy with other duties while waiting for assistance.

one testimony.

11. In a July 19, 2010, memorandum from an OHFLAC Manager to "All Approved Nurse Aide Training and Competency Education Programs (NATCEP) Programs and Contracted Vendor – Professional HealthCare Development," the following was listed as an example of neglect of a resident:

> Failure to report observed or suspected abuse, neglect or misappropriation of property.[6]

12. On May 9, 2011, Grievant was interviewed by Vicky Berkley and Stephanie Click. These two employees are members of the Lakin Hospital team that investigate allegations of suspected abuse or neglect at the Hospital.

13. Vicky Berkley asked Grievant to tell her about residents not being cared for on C Wing. Grievant responded: "When there are three people working the hall, it's hard to get everything done; turning, feeding, changing, etc.; nearly impossible. And to me that's neglect." Grievant specified that, in her opinion, the inability to always change residents clothes and bedding quickly has contributed to skin breakdown on two specific patients, C. C. and G. H.[7] Respondent's Exhibit 1. *See also* Footnote 5 *supra.*

14. When Grievant was asked by the interviewers whether she had reported her concerns to the nurses, Grievant stated that she thinks the nurses realize the problems and

---

[6] Respondent's Exhibit 14. Memorandum from Twonna Williams, RN Program Manager, Long-Term Care Nursing Assistance Program regarding, "Nursing Assistant Policy: Program changes related to abuse definitions."

[7] The initials of the patients are used herein to protect their privacy and because their specific identities are not essential to the resolution of this matter.

that they have seen them. Stephanie Click then asked, "When you pass the report to the next shift, do you tell them?" Grievant responded, "Yes."

15. Following this interview, Kim Billups, Director of Nursing, filled out and submitted two reports of neglect on Adult Protective Service Reporting Forms.[8] These forms are utilized to report allegations of suspected abuse or neglect of residents to the OHFLAC pursuant to 69 C.S.R. 6 § 3.2.a.[9]

16. The forms prepared and submitted by Director Billups reported that Grievant Williams had committed "neglect" of two specific residents by her "failure to report suspected/observed neglect." Respondent's Exhibit 2 and 3. Interestingly, no forms were submitted regarding Grievant's suspicions of neglect after the interview.

17. On May 10, 2011, Grievant met with Director Billups. Director Billups informed Grievant that she was suspended without pay while an investigation was conducted into whether she had committed "neglect" by failing to report her suspicion that patients were neglected as a result of the level of staffing. Grievant surrendered her Hospital keys and name badge to Director Billups.[10]

18. Grievant Williams was given a letter from CEO Dailey dated May 11, 2011, confirming her suspension without pay due to the ongoing investigation. The letter is

---

[8] Respondent's Exhibit 2 and 3.

[9] 69 C.S.R. 6 § 3.2.a. states: "When allegations of abuse, neglect, or misappropriation of property of a resident have been reported to a facility, the facility shall immediately complete and fax a Nurse Aide Registry Immediate Fax Reporting of Allegations to the Nurse Aid Program within twenty-four (24) hours." The Nurse Aide Registry Program is operated by OHFLAC.

[10] Respondent's Exhibit 5, an e-mail from Director Billups to Wanda Smith and CEO Dailey regarding the suspension of Grievant.

marked and signed as received by Sheila Williams, Grievant, on May 13, 2011. Respondent's Exhibit 19.

19. On the morning of May 13, 2011, Grievant Williams and her representative met with Director Billups and Vicky Berkley for a predetermination conference. During that meeting, Director Billups noted Grievant's prior testimony in the *Goodnite et al.* hearing and stated: "We need to know what your thoughts were when you voiced those statements." Grievant replied that it meant that they were so short of staff "that it's nearly impossible to get our work done" and it's stressful. Later in the meeting the following exchange occurred:

> [Director Billups] - OK, let's talk about that. They have 3 [staff assigned to C-wing] today, but I don't feel like neglect is occurring. We all have our own opinions. If you think neglect is occurring you need to report it.
>
> [Grievant Williams] - [W]e've said that over and over. I don't think it's fair the residents aren't getting the care they deserve. **It may not be neglect as we get around to it eventually;** I'd never do anything to hurt one of the residents. . .
>
> [Director Billups] - [W]hen "neglect" is said, we have to determine if it meets the definition, if it occurred, which is the purpose of the investigation. When you failed to report, we have to report that also.
>
> [Grievant Williams] - [E]ven though we went to the nurse and they see.[11]

(Emphasis added).

20. At the conclusion of the investigation, the Hospital management decided that the charge that Grievant was guilty of "neglect" for failing to immediately report suspected neglect of a resident, was substantiated. Director Billups called Grievant on May 17, 2011, and told Grievant she would be suspended for eighty hours without pay. Counting the time

---

[11] Respondent's Exhibit 7, notes of the predetermination meeting, signed by Director Billups and Grievant. The wording of the notes has only been altered to more specifically identify the speakers and provide capitol letters at the beginning of each quoted phrase.

Grievant had been suspended during the investigation, she was allowed to return to work on May 24.

21. A letter dated May 18, 2011, and signed by CEO Dailey, was sent to Grievant confirming the suspension which was communicated to her over the telephone by Director of Nursing Billups. The reason stated for the suspension was based upon the Hospital management's "decision to substantiate neglect regarding the allegation that [Grievant] had knowledge of suspected abuse or neglect and failed to report this allegation. . ." Respondent's Exhibit 21.

Discussion

As this grievance involves a disciplinary matter, the Respondent bears the burden of establishing the charges against the Grievant by a preponderance of the evidence. Procedural Rules of the W. Va. Public Employees Grievance Bd. 156 C.S.R. 1 § 3 (2008); *Nicholson v. Logan County Bd. of Educ.*, Docket No. 95-23-129 (Oct. 18, 1995); *Landy v. Raleigh County Bd. of Educ.*, Docket No. 89-41-232 (Dec. 14, 1989). "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); *Leichliter v. W. Va. Dep't of Health and Human Res.*, Docket No. 92-HHR-486 (May 17, 1993). Where the evidence equally supports both sides, the employer has not met its burden. *Id.*

From the outset, it is important to note that Grievant is regarded by her employer to be a good and valued employee. At the end of the predetermination meeting, Grievant

became upset and stated that she was embarrassed. Director Billups attempted to reassure Grievant Williams by stating: "There is no need to be embarrassed, I don't want you to be embarrassed. You are a good employee, we know that – there is nothing in your file about having to be talked to, directed, etc." Respondent's Exhibit 7. From the entire record produced in this matter including limited testimony from the *Goodnite et al.* grievance, it is apparent that one of the main motivating factors of Grievant William's participation in the *Goodnite et al.* grievance was her concern that the residents under her care get safe and adequate treatment. Likewise, it is equally apparent that the Hospital management's actions were out of concern for following strict rules related to reporting of allegations of suspected abuse and neglect of residents.

The facts are generally uncontested and the issue to be resolved is how those facts relate to the controlling law and policy. The West Virginia statutes and policies related to long-term care facilities require an employee to immediately report suspected abuse or neglect to her supervisor. Specifically, 69 C.S.R. 6 § 3.1.a states:

> Any employee of a facility, or anyone who provides services to a resident of a facility on a regular or intermittent basis, who suspects that a resident in a facility has been abused or neglected or that the resident's property has been misappropriated shall immediately report the incident to the facility administration and Adult Protective Services as required by W. Va. Code §9-6-9.

"Neglect" is defined as, "The unreasonable failure by a caregiver to provide the care necessary to assure the physical safety or health of an incapacitated adult." W. Va. Code § 9-6-1(3). In providing guidance of what constitutes "neglect" pursuant to the law and policies, The Long-Term Care Nursing Assistant Program RN Program Manager included

as an example, "Failure to report observed or suspected abuse, neglect or misappropriation of property." Respondent's Exhibit 14.

During Grievant's testimony in *Goodnite et al.,* she was describing the difficulties she encountered in meeting the needs of the residents on her wing when she was forced to work alone. She noted that it caused delays in service and that it was very stressful. Upon cross examination she was asked if she felt that the residents are neglected and she answered, "Sometimes." When she was asked if she reported her suspicion of neglect Grievant replied, "Um-hum.[12] Just complained about not enough help." At this point, CEO Daily became concerned that a suspected incident of neglect had not been reported. This concern raised potential problems for the Hospital because 69 C.S.R. 6 § 3.2.a. requires:

> When allegations of abuse, neglect, or misappropriation of property of a resident have been reported to a facility, the facility shall immediately complete and fax a Nurse Aide Registry Immediate Fax Reporting of Allegations to the Nurse Aid Program within twenty-four (24) hours." The Nurse Aide Registry Program is operated by OHFLAC.

Based upon this requirement, the Hospital could be out of compliance if it failed to report to OHFLAC that Grievant failed to report a suspected incident of neglect. After receiving advice about the incident CEO Daily commenced an investigation.

In her initial testimony and in all her subsequent statements, Grievant made it clear that she had told all of her concerns related to the residents to the nurses who were her supervisors. Grievant noted several times that the nurses knew of the situation. She properly reported to her supervisors all the facts that she believed constituted neglect.

---

[12] "Um- hum" is interpreted by the undersigned to mean "yes" based upon the context of the testimony and the undersigned's observation of many witnesses giving the same response.

Indeed she became so frustrated with no action being taken based upon her reported facts that she eventually filed a grievance to try to get the problems addressed through increased staffing. Unfortunately, throughout her reporting of these problems she never used the word neglect. In fact, she did not use that term until prompted to do so on cross examination. During the predetermination meeting, Grievant noted again that the nurses knew about the shortage of staff and how hard it was to meet the residents' needs. Then Grievant conceded that, "It might not be neglect as we get around to it eventually. . ."

Given the totality of the circumstances in this specific situation, it is clear that Grievant reported all of the facts and incidents related to the problems with care for the residents to her supervisors. Accordingly, she did not violate the requirements of 69 C.S.R. 6 § 3.1.a by failing to report an incident of suspected neglect.[13] It would certainly have been preferable for Grievant to have specifically noted that she thought that these facts and incidents amounted to neglect when she reported them, but the fact that she failed to do so in this particular situation does not negate the fact that she met her reporting obligation. Consequently, Respondent did not prove the charges against Grievant by a preponderance of the evidence.

W. Va. Code § 6C-2-3 (h) states:

> No reprisal or retaliation of any kind may be taken by an employer against a grievant or any other participant in a grievance proceeding by reason of his or her participation. Reprisal or retaliation constitutes a grievance and any person held responsible is subject to disciplinary action for insubordination.

---

[13] Likewise, Grievant did not commit "neglect" herself, by failing to report suspected neglect."

Grievant argues that she was suspended because she filed a grievance and testified that the Hospital was understaffed and it was affecting patient care. Because her suspension was related to her testimony, it is easy to see why Grievant would reach this conclusion. However, the evidence is clear that the suspension was related to the Hospital management's concerns that all of the reporting requirements relating both to the employees and the institution be followed strictly. Failure to follow these requirements could lead to serious consequences for all concerned. CEO Daily did not appear to hold any animus toward Grievant Williams nor any of the other employees who participated in the *Goodnite et al.* grievance. Additionally, Director Billups made it clear to Grievant that she was considered a good employee and had nothing for which she needed to feel ashamed. Grievant did not prove reprisal by a preponderance. In fact, all of the parties seemed to be acting in the way they felt was in the best interest of the residents of the Hospital throughout this situation. That they disagreed on how that was best accomplished does not diminish their efforts.

Because Respondent did not prove the charges against Grievant Williams by a preponderance of the evidence, the grievance is GRANTED.

Conclusions of Law

1. As this grievance involves a disciplinary matter, the Respondent bears the burden of establishing the charges against the Grievant by a preponderance of the evidence. Procedural Rules of the W. Va. Public Employees Grievance Bd. 156 C.S.R. 1 § 3 (2008); Nicholson v. Logan County Bd. of Educ., Docket No. 95-23-129 (Oct. 18, 1995); *Landy v. Raleigh County Bd. of Educ.*, Docket No. 89-41-232 (Dec. 14, 1989). "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); *Leichliter v. W. Va. Dep't of Health and Human Res.*, Docket No. 92-HHR-486 (May 17, 1993). Where the evidence equally supports both sides, the employer has not met its burden. Id.

2. The West Virginia statutes and policies related to long-term care facilities require an employee to immediately report suspected abuse or neglect to her supervisor. Specifically, 69 C.S.R. 6 § 3.1.a states:

> Any employee of a facility, or anyone who provides services to a resident of a facility on a regular or intermittent basis, who suspects that a resident in a facility has been abused or neglected or that the resident's property has been misappropriated shall immediately report the incident to the facility administration and Adult Protective Services as required by W. Va. Code §9-6-9.

3. Lakin Hospital is required to immediately report all incidents of suspected abuse or neglect of a resident to OHFLAC pursuant to 69 C.S.R. 6 § 3.2.a. which states:

> When allegations of abuse, neglect, or misappropriation of property of a resident have been reported to a facility, the facility shall immediately complete and fax a Nurse Aide Registry Immediate Fax Reporting of Allegations to the Nurse Aid Program within twenty-four (24) hours." The Nurse Aide Registry Program is operated by OHFLAC.

4. In the context of long-term nursing facilities such as Lakin Hospital, "Neglect" is defined as, "The unreasonable failure by a caregiver to provide the care necessary to assure the physical safety or health of an incapacitated adult." W. Va. Code § 9-6-1(3).

5. OHFLAC considers, "Failure to report observed or suspected abuse, neglect or misappropriation of property" to constitute "neglect" pursuant to W. Va. Code § 9-6-1(3).

6. Respondent did not prove the charges that Grievant failed to immediately report suspected incidents of neglect by a preponderance of the evidence.

Accordingly, the grievance is GRANTED. Respondent is Ordered to restore to Grievant all pay lost as a result of her eighty- hour suspension, plus statutory interest thereon and restore all benefits Grievant may have lost

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: MAY 10, 2012

WILLIAM B. MCGINLEY
ADMINISTRATIVE LAW JUDGE