WEST VIRGINIA PUBLIC EMPLOYEES GRIEVANCE BOARD

WILLIAM ROUSH,
Grievant,

v. **Docket No. 2011-1310-DHHR**

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

DECISION

This grievance was filed by William Roush, ("Grievant") against his previous employer, the Department of Health and Human Resources ("DHHR"). Grievant was employed by DHHR as a Certified Nursing Assistant in the classification of Health Services Worker at Lakin Hospital ("Hospital"). Mr Roush filed a level three[1] grievance form dated March 15, 2011, alleging that his employment at the Hospital was terminated without good cause. As relief, he seeks, "To be made whole, including back pay with interest & restored benefits."

_____The level three hearing was conducted at the office of the West Virginia Public Employees Grievance Board in Charleston on November 22, 2011, and February 28, 2012. On both days, Grievant appeared and was represented by Judith Warner, UE Local 170, West Virginia Public Workers Union. Respondent was represented by Harry C. Bruner Jr., Assistant Attorney General. At the conclusion of the hearing, both parties agreed to submit Proposed Findings of Fact and Conclusions of Law which were received by the Grievance

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[1] W. VA. CODE § 6C-2-4 (a)(4) authorizes an employee who is contesting termination of his employment to initially file a grievance at level three.

Board on April 12, 2012.[2] The grievance became mature for decision on that date.

Synopsis

Grievant was dismissed from employment for allegedly neglecting a resident by strapping him in a mechanical lift and then leaving the resident alone while Grievant went to find a co-worker to help with transferring the resident from his chair to his bed. Respondent also cited prior patient safety issues with Grievant. Grievant argues that no harm came to the patient in the incident and that he was not aware that proper procedure required that two workers be present when the patient was placed in the transfer mechanism. Respondent proved that Grievant failed to follow proper procedures for utilizing a mechanical lift, which met the definition of neglect of a patient. The charges against Grievant were proven by a preponderance of the evidence and the grievance is DENIED.

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. Prior to the termination of his employment, Grievant Roush had been employed by the Hospital continuously since April 7, 2007. Grievant was employed as a Certified Nursing Assistant in the Health Services Worker Classification.

2. Lakin Hospital in a long-term nursing facility. The residents served at the Hospital have special placement needs due to behavioral, developmental and other complex problems which require extensive care in a long-term facility.

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[2] The Proposals for the Grievant were signed by Gordon Simons, Steward, UE Local 170, West Virginia Public Workers Union.

3. On February 24, 2011, Grievant was working the night shift of the Hospital and patient C.H.[3] was one of the residents Grievant served.

4. C.H. is a fifty-seven year old male who suffers from the effects of a traumatic brain injury including: paralysis on one side; dementia with behavioral disturbance; mood, depression, anxiety, impulse control, and seizure disorders. C.H. does not communicate verbally. When he wishes to move from his chair to his bed C.H. often tries to slide out of the chair and into the floor. C.H. is not ambulatory and must be moved from his chair to his bed by the Hospital staff, including Grievant.

5. Non-ambulatory residents, such as C.H. are moved from chairs to bed by use of a lifting device that is often referred to as a Hoyer[4] lift. The lift regularly used to move C.H. is an Invacare mechanical lift. It operates by placing a large sling under the resident that continues up to support the back. Straps from the sling are then attached to a metal arm that is used to mechanically lift the resident so that he may be safely transferred to a different location. The sling used to transfer C.H. had six straps; two near the back of his shoulders, two along the outside of his thighs, and two that went between his legs and cris-crossed, so that he could not slide forward and out of the sling.[5]

6. All staff, including Grievant, receive annual training regarding the proper use

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[3] The resident's initials are used in this decision rather than his full name to protect his privacy interests. The parties and witnesses used initials for this, and other residents at the Hospital, at the level three hearing for the same reason.

[4] The term Hoyer lift is used because the first lifts were made by the Hoyer Company. The name became the generic term used for the lift devices regardless of the manufacturer, much like a copying machine is often referred to as a Xerox.

[5] Grievant's Exhibit 1 is a picture of a dummy strapped in the Invacare lift using the six-strap sling.

of the lift. At the training, proper lifting procedure must be demonstrated and it is stressed that two staff members are needed each time the lift was used. A copy of the manufacturer's installation and operating instructions are at the nurses station in each unit of the Hospital. These instructions contain the following statement:

> Invacare recommends that two (2) assistants be used for all lifting preparations, transferring from and transferring to procedures. The use of one (1) assistant is totally based on the evaluation of the healthcare professional for each individual case.[6]

7. The Lakin Hospital Policy and Procedure Manual Section Number L.201-6 sets out the Hospital Lifting/Transfer Policy. The policy states that compliance with the lifting/transfer policy is mandatory and that no resident may be lifted or transferred in contradiction to the policy.[7] The policy also notes that the operating instructions for the Commercial lifts are on all units for the staff to refer to for proper usage. One of the "key points" that is stressed in the training which accompanies the policy is that "Invacare recommends that two (2) assistants be used for all lifting preparations, transferring from and transferring to procedures." On June 8, 2007, Grievant signed an acknowledgment that he received the policy and was instructed in the proper techniques for the Hospital's lift and transfer equipment. Respondent's Exhibit 4.

8. Around 8:00 p.m. on February 24, 2011, Grievant was putting pads on a bed when a nurse told him that C.H. was sliding out of his chair which indicated that C.H. wished to be transferred to his bed. Grievant was by himself at the time. He strapped C.H.

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[6] Respondent's Exhibit 3, Invacare, *Manual/Electronic Portable Patient Lift Owner's Installation and Operating Instructions.*

[7] Respondent's Exhibit 4.

into the sling and attached the sling to the lift utilizing all six straps. He did not lift Grievant from the chair. Grievant waited for his co-worker, Jill Surbaugh, to arrive so that he could complete the transfer of C.H. from his chair to his bed. After a short period of time Grievant called into the hall and inquired about Ms. Surbaugh. The licensed practical nurse ("LPN") on duty, Melanie Thomashuna, indicated that the co-worker was not there. Grievant left C.H. strapped into the lift in his chair and went to the dining room to find his co-worker.

9. There are video cameras in the hallways of the Hospital. A review of the video for February 24, 2011, demonstrated that Grievant left the unit to find his co-worker at 8:05 p.m. and returned to the unit at 8:11 p.m.

10. While Grievant was looking for Ms. Surbaugh, LPN Thomashuna was dispensing medication to the patients. She entered the room of C.H. and saw that he was alone and strapped into the transfer sling and attached to the lift. The lift sling was covering the resident's face. The sling would not cover the resident's face if it were properly adjusted. The LPN called for assistance with the resident.

11. Another Health Service Worker, Renee Blankenship, heard LPN Thomashuna's call and came to assist her in removing C.H. from the lift.

12. When Grievant and Ms. Surbaugh returned to the room, C.H. was out of the sling and LPN Thomashuna was in the room with C.H.[8] The three of them placed C.H. in the lift and transferred him into his bed. LPN Thomashuna left the room and reported the

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[8] LPN Thomashuna was angry that Grievant had left C.H. alone and strapped into the lift. She reminded Grievant that C.H. was known to slide out of his chair and told Grievant that the sling had somehow covered the resident's face.

incident to the nurse in charge of the shift, Bernice Campbell.

13. No apparent harm came to C.H. while he was strapped to the chair and left alone in his room.

14. By letter dated February 28, 2011,Linda Daily, Chief Executive Officer of Lakin Hospital ("CEO"), informed Grievant that he was suspended without pay while an investigation was conducted into an allegation of neglect as a result of his actions on February 24, 2012, involving C.H.

15. During the investigation, Grievant gave a statement describing the incident involving strapping C. H. into the lift. Grievant admitted that he placed the resident in the sling, attached the straps to the lift and then left to get his co-worker. Grievant was asked if that was his normal practice and he answered, "Yes, to hook him up and leave. I usually go to the doorway and get help."[9]

16. In a memorandum dated July 19, 2010, Twonna Williams, RN Program Manager for the WV Long-Term Nursing Assistant Program, set out the definition of "neglect" as it relates to Nursing Assistants in State Health Facilities as follows:

> Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

The memorandum lists examples of neglect, one of which is, "Failure to take precautionary measures, such as use of bed rails, as ordered, to protect the health and safety of the resident." Respondent's Exhibit 2.

17. Lakin Hospital has a committee which investigates each allegation of abuse

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[9] Respondent's Exhibit 15, Grievant's statement taken by Director of Nursing, Kim Billups and Social Work Supervisor Stephanie Click.

and neglect based upon the definitions of those terms found in state and federal regulations. CEO Dailey; Director of Nursing, Kim Billups; Social Work Supervisor, Stephanie Click; and Staff Development Nurse, Andrea Hill-Murphy, were on the committee to investigate the neglect allegation against Grievant Roush.

18. The committee determined that Grievant's actions of placing C.H. in the lift by himself and then leaving C.H. unattended in the lift while he searched for his co-worker met the definition of neglect. The committee reviewed Grievant's employment record to determine what discipline would be appropriate.

19. Grievant was rated as "Meets Standards" on all of his Employee Performance Appraisals. Grievant's Exhibit 2. However, Grievant had a number of serious performance issues brought to his attention prior to the incident on February 24, 2012. Respondent's Exhibit 11.

20. On April 23, 2009, Grievant received Job Performance Observation[10] ("JPO") related to a resident who was found alone on the floor of the shower. Grievant was assigned to the patient who was supposed to be kept in the Health Service Worker's line of sight. The resident was found in the shower, on the floor, by a nurse.[11] Grievant was reminded that residents must never be left in the shower alone.

21. On April 28, 2010, Grievant received a JPO about taking breaks that were

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[10] A Job Performance Observation is a form upon which a supervisor may note an incident where an employee is doing well or has made mistakes that need corrected. When the Observation is negative the employee is instructed as to how to correct the deficiency.

[11] Grievant denied placing the resident in the shower and leaving him alone but did not explain how the resident got there when he was supposed to be constantly in Grievant's line of sight.

longer than allowed.

22. On May 29, 2009, Grievant was given an Individual Education Plan related to an incident where he had given a resident regular bread to eat even though the resident was on a diet plan that required all of his food to be pureed. Grievant was reminded to not feed a resident without checking to ensure that the meal was consistent with the resident's diet card and order. Failure to follow the proper diet instructions could lead to serious health problems, including choking and allergic reactions.

23. On November 5, 2009, Grievant was counseled for violating Hospital policy against taking pictures on the Hospital premises. Grievant was taking a video of a co-worker as part of a graduate school project. Both employees were off duty for 55 minutes taking the video.

24. On November 24, 2009, Grievant was observed sitting and watching television while his co-worker, Jill Surbaugh, was providing services to the residents to whom he was assigned. A supervisor who observed this told Grievant to get up and get to work. Grievant ignored her. The supervisor nurse in charge of the shift was called, and assigned Grievant work to do.

25. On January 30, 2010, a JPO was issued to Grievant for passing a resident in the hall who was leaning against the wall and vomiting. When asked about the resident, Grievant stated that the staff on A-wing was responsible for her. Grievant not had rendered aid to the resident nor notified A-wing staff of the resident's distress.

26. On August 12, 2010, Grievance was given a memorandum from Nurse Vicky Berkley regarding skin care. Grievant had given a resident a shower without removing a wound dressing. Grievant was instructed to never leave a wet dressing against a resident's

skin and that if he was uncomfortable removing the dressing he was to contact the unit nurse and delay the shower until the dressing is removed.[12]

27. By letter dated March 7, 2011, CEO Dailey informed Grievant that he was dismissed from employment with the Hospital. She sited the incident of neglect involving C.H. as well as "multiple attempts at counseling [Grievant] on patient safety" and Grievant's conduct over the preceding two years.[13]

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.*

Since Grievant was a tenured employee in the state's classified service, the

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[12] All of the documents set out in Findings of Fact 20 through 26 were included in Respondent's Exhibit 11. Two other JPOs were included in the exhibit. Grievant testified that he was told that those two JPOs would be removed from his file. Consequently, they are not addressed herein.

[13] Respondent's Exhibit 1.

Respondent must also demonstrate that the misconduct which forms the basis for the dismissal was of a "substantial nature directly affecting rights and interests of the public." *House v. Civil Serv. Comm'n*, 181 W. Va. 49, 380 S.E.2d 226 (1989). "The judicial standard in West Virginia requires that 'dismissal of a civil service employee be for good cause, which means misconduct of a substantial nature directly affecting rights and interests of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention.' Syl. Pt. 2, *Buskirk v. Civil Service Comm'n*, [175 W. Va. 279,] 332 S.E.2d 579, 581 (W. Va. 1985); *Oakes v. W. Va. Dept. of Finance and Admin.*, [164 W. Va. 384,] 264 S.E.2d 151 (W. Va. 1980); *Guine v. Civil Service Comm'n*, [149 W. Va. 461,] 141 S.E.2d 364 (W. Va. 1965)." *Scragg v. Bd. of Dir./W. Va. State College*, Docket No. 93-BOD-436 (Dec. 30, 1994).

Respondent dismissed Grievant for failing to follow the standard safety procedure for using the mechanical device for lifting and transferring a resident from his chair to his bed by strapping the resident into the lift device by himself instead of having two staff present during the process. Grievant then exacerbated this error by leaving the resident alone and helplessly strapped to the device while Grievant went in search of his co-worker to help complete the transfer. Respondent found that this action met the definition of neglect of a resident which is defined as "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." Respondent's Exhibit 2.[14] A set of clarifying examples of neglect has been provided to the nursing facilities which includes, "Failure to take precautionary measures, such as use of bed rails, as ordered, to protect the

[14] This definition of "neglect" for nursing facilities is also set out in the West Virginia Code of State Rules at 69 C.S.R. 6 § 2.4.

health and safety of the resident." Respondent's Exhibit 2. Respondent argues that Grievant's actions were inconsistent with the specific safety procedures established for operation of the Invacare lift and, therefore, subjected the resident to the risk of physical harm.

Grievant argues that he knew of the requirement that two staff members be present during the transfer procedure but he did not know that two people had to be present to place the resident in the sling and attach him to the lift. Indeed, he told the Director of Nursing that his standard procedure was to place C.H. in the sling, strap him up to the lift, and then go to the door and call for a co-worker to help with the transfer. Grievant points out that C.H. was only left alone for five or six minutes and no harm came to him during that time. Therefore, Grievant avers that Respondent failed to prove neglect. This argument is not convincing. The manufacturer's instructions, which are available at each nursing station, and are the basis of the training Grievant received on multiple occasions, specify that two staff members are to "be used for ALL lifting **preparation"**[15] and transferring procedures. Respondent's Exhibit 3. Also, Andrea Hill-Murphy, who coordinates all of the training at the Hospital, testified that staff is trained that two people must be present for all of the lift procedure, including placing the resident in the lift. Finally, Grievant's argument that the resident was only left alone for a few minutes and suffered no apparent harm, highlights his failure to understand the need for safety procedures. The mere fact that C.H. cannot communicate does not mean that he has no understanding of his situation. One can only imagine his trepidation when he was strapped in a device, unable to move, and left that

[15] Respondent Exhibit 3. (Capitalization of "ALL" is in the original. The additional emphasis is added.)

way while the only person charged with his welfare leaves the room.

Respondent proved that Grievant's actions related to C.H. on February 24, 2012, constituted neglect as that term applies to nursing facilities. When that incident is viewed in the light of Grievant's entire employment record, Respondent proved the charges against Grievant by a preponderance of the evidence. Accordingly, the grievance is DENIED.

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).

2. Grievant was a tenured employee in the classified service. "The judicial standard in West Virginia requires that 'dismissal of [such an] employee be for good cause, which means misconduct of a substantial nature directly affecting rights and interests of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention.' Syl. Pt. 2, *Buskirk v. Civil Service Comm'n*, [175 W. Va. 279,] 332 S.E.2d 579, 581 (W. Va. 1985); *Oakes v. W. Va. Dept. of Finance and Admin.*, [164 W. Va. 384,] 264 S.E.2d 151 (W. Va. 1980); *Guine v. Civil Service Comm'n*, [149 W. Va. 461,] 141 S.E.2d 364 (W. Va. 1965)." *Scragg v. Bd. of Dir./W. Va. State College*, Docket No. 93-BOD-436 (Dec. 30, 1994).

3. Respondent proved by a preponderance of the evidence that Grievant had committed "neglect" of a resident as that term is defined in 69 C.S.R. 6 § 2.4.

4. Considering Grievant's employment history and the incident of neglect, Respondent proved by a preponderance of the evidence that there was good and just cause to terminated Grievant's employment.

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: AUGUST 17, 2012

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WILLIAM B. MCGINLEY
ADMINISTRATIVE LAW JUDGE