

COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2014-047

ERIC J. BRINEGAR

APPELLANT

VS. FINAL ORDER
SUSTAINING HEARING OFFICER'S
FINDINGS OF FACT, CONCLUSIONS OF LAW
AND RECOMMENDED ORDER

CABINET FOR HEALTH AND FAMILY SERVICES
J.P. HAMM, APPOINTING AUTHORITY

APPELLEE

** ** *

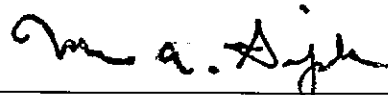
The Board at its regular November 2014 meeting having considered the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer dated October 20, 2014, and being duly advised,

IT IS HEREBY ORDERED that the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer be, and they hereby are approved, adopted and incorporated herein by reference as a part of this Order, and the Appellant's appeal is therefore **DISMISSED**.

The parties shall take notice that this Order may be appealed to the Franklin Circuit Court in accordance with KRS 13B.140 and KRS 18A.100.

SO ORDERED this 19th day of November, 2014.

KENTUCKY PERSONNEL BOARD



MARK A. SIPEK, SECRETARY

A copy hereof this day sent to:

Hon. Jennifer Wolsing
Eric J. Brinegar
J.P. Hamm

**COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2014-047**

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**V. FINDINGS OF FACT, CONCLUSIONS OF LAW
AND RECOMMENDED ORDER**

**CABINET FOR HEALTH AND FAMILY SERVICES,
J. P. HAMM, APPOINTING AUTHORITY**

APPELLEE

** ** ** ** ** **

This matter came on for an evidentiary hearing on September 18, 2014, at 9:30 a.m., at 28 Fountain Place, Frankfort, Kentucky, before the Hon. R. Hanson Williams, Hearing Officer. The proceedings were recorded by audio/video equipment and were authorized by virtue of KRS Chapter 18A.

The Appellant, Eric J. Brinegar, was present at the evidentiary hearing and was not represented by legal counsel. The Appellee, Cabinet for Health and Family Services, was present and represented by the Hon. Jennifer Wolsing. Appearing as agency representative was Ms. Tina Ashley.

This matter involves the five-day suspension given to the Appellant for unsatisfactory performance of duties, as evidenced by letter dated January 29, 2014 (**a copy attached hereto as Recommended Order Attachment 1**).

The Appellee was assigned the burden of proof by a preponderance of the evidence to show that the action taken was neither excessive nor erroneous and was appropriate under all surrounding circumstances.

BACKGROUND

1. The Appellee's first witness was **Ted Chappell**. He has been employed at the Hazelwood facility in Louisville, Kentucky, as a Program Investigative Officer I for approximately three years. Hazelwood is a facility which deals with individuals with intellectual disabilities. Part of Chappell's duties includes investigations of injuries and abuse allegations at the facility, which is an intermediate care facility-mental health (ICF-MH).

2. Chappell introduced Appellee's Exhibit 1, which contained his investigative report concerning Client 1's injury. In summary, the findings of this report were that on

September 27, 2013, in Unit 3 East at Hazelwood facility, at approximately 10:30 a.m., the Appellant took Client 1, who was strapped into a wheelchair, to the bathroom. When Appellant arrived at the bathroom, he removed the leg rests and armrests, so as to allow Client 1 to go into the bathroom. The report further finds that upon returning Client 1 to his wheelchair, the Appellant strapped him in the wheelchair, but forgot to replace the armrests. Subsequently, the Client leaned to the left side while in the chair, and as a result of the armrests not being in place, fell to the floor, along with the wheelchair. This resulted in injuries to Client 1, from his head striking the floor, causing a knot and at least two red spots on his head after contact with the floor.

3. Chappell then introduced an incident report and investigative statements from both the Appellant and Therapist Brad Clark, both of which confirm that the armrests were not replaced on the wheelchair. He also introduced Appellee's Exhibit 8, a risk management plan for Client 1, which indicates he is at risk for fractures and falls related to being diagnosed with osteoporosis.

4. Photos of Client 1 taken immediately after the fall show bumps and redness, as previously related above. (Appellee's Exhibit 11 photos were placed under seal.)

5. On cross-examination, Chappell was asked if the armrests mentioned herein are described anywhere as a safety device, to which the witness replied he did not know.

6. The Appellee's next witness was **Sharon Probus**. She is a LPN working for Guardian Healthcare, although assigned to the Hazelwood facility. She introduced Appellee's Exhibit 4, her statement taken after the accident. She confirmed that she was at the medicine room on the day of the accident, with the client being just outside. At some point, she heard a loud bang, and turned to see Client 1 on his side, still strapped into the wheelchair. She testified that she is trained on the stand-pivot transfer, which should have been used in this case, and further stated that it is very dangerous for someone in a wheelchair if all the parts are not replaced.

7. The Appellee's next witness was **Sara Ballew**. She has been a physical therapy assistant at Hazelwood for the previous five years. She introduced various documents which indicated that on July 23, 2012, various aides, including the Appellant, had been trained on wheelchair transport and tie-downs. This training included how to position and re-position a client in a wheelchair. She further introduced documents showing that following the initial in-service training, the Appellant had been given re-training on August 21, 2012, on the lift and transfer procedures, which included the stand-pivot transfer.

8. Ballew testified that the patient aides normally used the stand-pivot transfer every two hours because of the toileting needed by the clients. She added that generally the aides do not forget the steps involved in this procedure, since they do it so often. She also explained that on October 8, 2013, the Appellant had been given training on the lift and transfer procedure.

9. On cross-examination, Ballew stated that the armrests are considered as positioning devices, and not safety devices.

10. The Appellee's next witness was **Linda Hampton**. She has been employed at Hazelwood for approximately nine years, and at the time of the incident was a certified nursing assistant. She introduced Appellee's Exhibit 18, a shift home log, which shows she was taking care of Client 1 on the day in question. This log also further shows that she was called back to the floor at approximately 11:00 a.m. (**Hearing Officer Note: This would have been following the incident which occurred on or around 10:40 a.m.**)

11. On cross-examination, Hampton testified that on that date she went to the work activities module when Ashley Clark relieved her for lunch. At that time, Client 1 was not in her module.

12. The Appellee's next witness was **Ashley Clark**. She has been involved in direct patient care at Hazelwood, which involves feeding, bathing and transferring clients. Clark testified that at approximately 11:30 a.m., she covered Linda Hampton's group during the lunch break. At that time, the Appellant was not in charge of that group.

13. The Appellee's next witness was **Brenda Wilhelm**. She is also employed at Hazelwood in direct patient care. She testified she has been trained on the stand-pivot transfers and, as a result, knows to replace the parts of a wheelchair after placing a client back in the chair. She added that it is dangerous not to replace these parts.

14. The Appellee's next witness was **Toni Hall**. She is a rehabilitation instructor at Hazelwood, and has been employed there for approximately 20 years. As an instructor, she trains clients on their individual daily living skills. She testified that on the day in question, she had relieved Brenda Wilhelm for her lunch break at approximately 10:30 a.m., and at that time was responsible for the group. She introduced Appellee's Exhibit 20, a copy of the Appellant's home log for the day in question, which indicated she had covered for him at his lunch break at approximately 11:00 a.m.

15. On cross-examination, Hall testified that there were no one-on-one clients in her module on the day in question, and that the aides were temporarily transporting clients from the EC to the floor. During the time in question, there were approximately six clients in her module.

16. The Appellee's next witness was **Tina Ashley**. She is a long-time employee of Hazelwood, and for the past three years has been the Human Resources Director. She is familiar with the policies and procedures of the facility.

17. Ashley introduced Appellee's Exhibit 21, the Misconduct/Non-Threatening Policy 7.13.2. She testified that the Appellant's actions in not replacing the armrests after having been trained on doing so, were considered non-threatening and unsatisfactory work performance.

18. Ashley also introduced Appellee's Exhibit 23, Policy No. 12.1, dealing with Risk Management and Safety. This policy specifically deals with the level of supervision as relates to aides and patients. This policy provides that the staff to client ratio is one:four under a support

level of supervision. Ashley added that the facility was not considered understaffed on the day in question.

19. The next witness to be called by Appellee was **Jack Barnett**. He has been a Human Resources Administrator within the Office of Human Resource Management for approximately three and one-half years. His duties include handling requests for major disciplinary action. As such, he reviews the files, and in this case, the requested action for the Appellant was assigned to him.

20. Barnett introduced Appellee's Exhibit 22, the Personnel Procedures Handbook 2.1, dealing with EMPLOYEE CONDUCT. Under this policy is "Lack of Good Behavior." Although a lengthy list of examples is stated, none particularly pertain to the incident herein. However, it should be noted that the guidelines are cited as examples of such guidelines, "including, but not limited to..."

21. Asked to justify his request for a five-day suspension in this case, Barnett stated it was comparable to two similar cases from the Glasgow office, in which a client wandered off on his own and fell. In those cases, Barnett stated the aides received five-day suspensions.

22. On cross examination, Barnett also confirmed that the armrests were not named as safety devices in the various explanations of procedures.

23. The Appellee's next witness was **Jay Klein**. He has been the Appointing Authority at the agency for approximately 15 years. After receiving a request for major disciplinary action against the Appellant from Hazelwood, Klein directed his staff to investigate and give him recommendations. As a result, the suspension letter of January 29, 2014, was issued to the Appellant. Asked why a five-day suspension was appropriate, Klein replied that the actions herein were dangerous and, to forget something so vital, made the patients very vulnerable to injury such as the one which occurred herein. With that, the Appellee closed.

24. The Appellant called as his first witness **Nick Senior**. He has been a Therapeutic Program Supervisor Assistant at Hazelwood for approximately the past three years. Upon questioning, it was determined that this witness was not at the facility on the day in question.

25. Appellant's next witness was **Todd McGuire**. He performs the same function at Hazelwood as did Nick Senior. He testified he was aware of incidents at the Bingham Gardens facility, formerly under the auspices of the Cabinet, when residents fell because they were not buckled into a wheelchair. He has no knowledge of whether an employee, Val Orberson, was ever disciplined for these incidents, and stated he did not know if the clients were injured during those falls.

26. McGuire examined Exhibits 19 and 20, and confirmed there were a total of seven clients listed as being under care at or around 10:30 a.m. that day. In eliciting this information, the Appellant was apparently trying to suggest that there were too many clients to be adequately watched over, and that this was a violation of the one:four staff-to-client ratio.

27. The Appellant, **Eric J. Brinegar**, called himself as his last witness. He testified he was not supposed to have been responsible for in excess of four clients on the day in question. He testified that the previous exhibits cited showed there were either six or seven clients on the floor at the time of the incident.

28. The Appellant further stated that the armrests in question were not described as safety devices in the training manual at Hazelwood, and therefore he could not have acted against policy. He added that the armrests are not listed as necessary for a client's safety in the Risk Management sheet.

29. On cross-examination, the Appellant admitted the clients which were being transported from Module 351 to 3 East on the day in question for being transported one at a time. He also admitted that the training manuals state that the armrests must be replaced if removed. He was aware of that on the day in question.

FINDINGS OF FACT

1. On September 27, 2013, the Appellant transported Client 1, at approximately 10:30 a.m., to a restroom. The client was in a wheelchair and the Appellant removed the right footrest and both armrests to allow transfer of the client into the restroom.

2. After transferring the client back from the restroom into the wheelchair, the Appellant failed to reattach the armrests.

3. As a direct result of this failure, Client 1 leaned left far enough so as to cause the wheelchair to tip over with him in it, resulting in injuries to the client's head and face.

4. The Appellant, both by training and experience, was aware that it was necessary to have the armrests attached on the wheelchair.

5. Hazelwood Policy 7.13.2, Misconduct: Non-Threatening, Procedure (1) states:

PROCEDURE:

1. Misconduct that is non-threatening in nature is defined as a breach of State law, personnel rules, departmental rules, regulations or policies, and/or facility rules or policies which are of a non-threatening or non-dangerous nature. Misconduct that is non-threatening in nature includes, but is not limited to, the following:

- A. Insubordination.
- B. Leaving work station without authorization.
- C. Forgery – falsifying documents or signatures.
- D. Gambling – games of chance or skill for money or profit.
- E. Profanity and vulgarity.
- F. Unsatisfactory work performance.

- G. Poor attendance record.
- H. Tardiness.
- I. Job Abandonment.
- J. Failure to perform duties as assigned.
- K. Unprofessional conduct.

6. The Appellant's actions of not reattaching the armrests and causing the client's injuries were a violation of Hazelwood Policy 7.13.2 and constituted Unsatisfactory Performance of Duties under 101 KAR 1:345.

7. The Appellant's prior disciplinary record included a written reprimand.

CONCLUSION OF LAW

The Hearing Officer concludes as a matter of law that the Appellee carried its burden of proof to show the five-day suspension was neither excessive nor erroneous and was appropriate under all surrounding circumstances. KRS 13B.090(7) and KRS 18A.095(1) and (22).

RECOMMENDED ORDER

The Hearing Officer recommends to the Personnel Board that the appeal of **ERIC J. BRINEGAR V. CABINET FOR HEALTH AND FAMILY SERVICES, (APPEAL NO. 2014-047)** be **DISMISSED**.

NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13B.110(4), each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file exceptions to the Recommended Order with the Personnel Board. In addition, the Kentucky Personnel Board allows each party to file a response to any exceptions that are filed by the other party within five (5) days of the date on which the exceptions are filed with the Kentucky Personnel Board. 101 KAR 1:365, Section 8(1). Failure to file exceptions will result in preclusion of judicial review of those issues not specifically excepted to. On appeal a circuit court will consider only the issues a party raised in written exceptions. See *Rapier v. Philpot*, 130 S.W.3d 560 (Ky. 2004).

Any document filed with the Personnel Board shall be served on the opposing party.

The Personnel Board also provides that each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file a Request for Oral Argument with the Personnel Board. 101 KAR 1:365, Section 8(2).

Each party has thirty (30) days after the date the Personnel Board issues a Final Order in which to appeal to the Franklin Circuit Court pursuant to KRS 13B.140 and KRS 18A.100.

ISSUED at the direction of **Hearing Officer R. Hanson Williams** this 20th day of October, 2014.

KENTUCKY PERSONNEL BOARD



MARK A. SIPEK
EXECUTIVE DIRECTOR

A copy hereof this day mailed to:

Hon. Jennifer Wolsing
Mr. Eric J. Brinegar



Received

JAN 31 2014

Personnel Board

**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HUMAN RESOURCE MANAGEMENT**

Steven L. Beshear
Governor

275 East Main Street, 5C-D
Frankfort, KY 40621
502-564-7770
FAX 502-564-3129
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

January 29, 2014

Eric J. Brinegar

Re: Five (5) Day Suspension

Dear Mr. Brinegar:

Based on the authority of KRS 18A.095 and 101 KAR 1:345, you are hereby notified that you are officially suspended from duty and pay for a period of five (5) working days. The effective dates of your suspension are February 7, 2014; February 8, 2014; February 9, 2014; February 10, 2014; and February 11, 2014.

In accordance with 101 KAR 1:345, Section 1, you are being suspended from your position as a Patient Aide II with the Department for Behavioral Health, Developmental and Intellectual Disabilities, Hazelwood Center for the following specific reason:

Unsatisfactory Performance of Duties. As reported by Facility Director Melissa Brock, you failed to follow proper transfer procedures which lead to injuries to Client *1.

Specifically, on September 27, 2013, you were working from 6:00 a.m. until 2:15 p.m., on 3 East at Hazelwood Center. At approximately 10:30 a.m., you took Client *1 to Bathing Room C11 to check him for wetness. You removed the right footrest and both armrests from Client *1's wheel chair in order to safely perform a "stand-pivot" transfer of Client *1 from the wheelchair to the bathing slab. When you finished checking Client *1 for wetness, you placed him back into his wheelchair, reattached the footrest, but failed to reattach the armrests.

At approximately 10:40 a.m., Guardian Nursing contract Licensed Practical Nurse (LPN) Sharon Probus was in the medication room, room 333 on 3 East, when she heard a loud noise in the TV area, room 331. According to Ms. Probus' written statement dated September 27, 2013, she saw Client *1 "lying on floor on his left side & [with] his w/c [wheelchair] still secure & [with] w/c [wheelchair] belt." Ms. Probus noted injuries to Client *1's head, forehead, and temple and provided appropriate medical aid. Ms. Probus also reported in her statement,



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"Noted w/c [wheelchair] without arms & [and] someone questioned if that was his [Client *1's] normal w/c [wheelchair]. DCP [Direct Care Professional] [you] that had been caring for client then left area, went to bathroom & [and] came back & [with] 2 armrest (sic). He [you] stated he [you] had forgot (sic) them."

According to your written statement dated September 27, 2013, you admitted you "forgot to replace [Client *1's] arm wrests (sic)." You admitted, "Nothing caused me to forget to replace [Client *1's] arm wrests (sic). I simply forgot to do so in this instance."

An internal investigation concerning this incident was conducted by River Valley Behavior Health contract Program Investigator Officer Theodore Chappell. That investigation concluded Client *1 "tipped over in his wheelchair and fell to the floor on 9-27-13 at or around 10:40 AM because DCP Eric Brinegar, after taking [Client *1] to the bathroom around 10:30 AM, "simply forgot" to replace the armrests on [Client *1's] wheelchair. [Client *1] likely leaned to the left side while in the chair and, as a result of the armrests not being in place, fell to the side along with the wheelchair."

You received training on lifting and transferring procedures on July 20, 2012 and July 23, 2012. This training specifically instructed you to "Replace armrests and leg rests if they were removed" when performing Stand Pivot Transfers. You knew or should have known that failing to replace the armrests on Client *1's wheelchair placed Client *1 in a potential harmful situation.

Your actions violate Hazelwood Facility Policy 7.13.2, Misconduct: Non-Threatening; the Cabinet for Health and Family Services' Personnel Procedures 2.1, Employee Conduct; and constitute unsatisfactory performance of duties for which you may be disciplined pursuant to 101 KAR 1:345, Section 1.

You previously received the following action(s):

<u>DATE</u>	<u>ACTION</u>	<u>REASON</u>
January 8, 2013	Written Reprimand	Lack of Good Behavior/Poor Time and Attendance

To keep confidential the identity of Client *1 as required by law, the name of the patient referred to is transmitted by the attached list marked "CONFIDENTIAL" which is not to be disclosed without proper authorization. Further, you are not authorized to disclose the following client's name to anyone, including any attorney who may be representing you as counsel.

Further incidents in violation of policy may lead to further and more severe disciplinary action, up to and including dismissal.

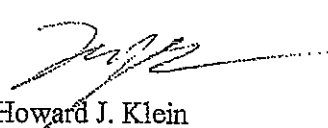
For your information, the Kentucky Employee Assistance Program (KEAP) is a voluntary and confidential assessment and referral service for state employees. This service may help you with any

Eric J. Brinegar
January 29, 2014
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personal problems that may be affecting your job performance. KEAP can be reached at 1-800-445-5327 or (502) 564-5788.

As you are an employee with status, you may appeal this action to the Personnel Board within sixty (60) days after receipt of this notice, excluding the day of receipt. To appeal, you must complete the attached form and direct it to the address indicated on the form. Copies of KRS 18A.095 and 101 KAR 1:365 concerning appeal and hearing procedures are enclosed.

Sincerely,



Howard J. Klein
Appointing Authority

HJK:jcb

Attachments

cc: Secretary Tim Longmeyer, Personnel Cabinet
Executive Director Mark Sipek, Personnel Board
Facility Director Melissa Brock, Hazelwood Center
Cabinet Personnel File