CERTIFICATION OF PERSONNEL BOARD RECORDS

I certify that attached hereto is a true and correct copy of the Findings of Fact, Conclusions of Law and Recommended Order and Final Order Altering in the case of **ASHLEY LEWIS VS. CABINET FOR HEALTH AND FAMILY SERVICES (Appeal No. 2013-028)** as the same appears of record in the office of the Kentucky Personnel Board.

Witness my hand this 14th day of January, 2014.

MARK A. SIPEK, SECRETARY
KENTUCKY PERSONNEL BOARD

Copy to Commissioner, Department of Personnel

COMMNWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2013-028

ASHLEY LEWIS **APPELLANT**

VS. **FINAL ORDER ALTERING 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 January 2014 meeting having considered the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer dated November 19, 2013, having noted Appellant's exceptions, Appellee's response to exceptions, and being duly advised,

IT IS HEREBY ORDERED that the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer be altered as follows:

A. **Delete** Findings of Fact, paragraphs 9 through 12, and substitute the following:

9. The Board finds the testimony of witnesses Soliah Nelson and Sharon Spencer to be unreliable and specifically finds the testimony of Appellant as to the ultimate question of whether she diluted Resident #1's orange juice or coffee to be persuasive. Having so found, the Board finds that those allegations in the disciplinary letter have no merit.

10. The Board finds that no testimony was presented from Josephine Morris or Donna Davis regarding allegations attributed to them in the disciplinary letter and lacking evidence finds those allegations have no basis.

4. While the Board is mindful and sensitive to the Appellee's oft-stated reliance and adherence to a "zero tolerance" policy regarding patient abuse or neglect, and the need to take disciplinary action should investigation substantiate allegations of abuse or neglect in one of the facilities it operates, the Board is also mindful that such allegations must be proven at evidentiary hearing per KRS Chapter 13B and KRS Chapter 18A.

5. Based on the Findings of Fact, as altered above, the Board concludes that as a matter of law of the Appellee, Cabinet for Health and Family Services, failed to carry its burden of proof by a preponderance of the evidence to demonstrate that Appellant committed the allegations as alleged in the disciplinary letter. Both determination of the Hearing Officer and the Board that the testimony presented by Nelson and Spencer was unreliable and the lack of any testimony from Josephine Morris, Donna Davis or Dr. Vance, who are attributed as sources of allegations against Appellant in the disciplinary letter, leads the Board to conclude the charges must fail.

C. **Delete** the Recommended Order, and substitute the following:

IT IS HEREBY ORDERED that the appeal of **ASHLEY LEWIS VS. CABINET FOR HEALTH AND FAMILY SERVICES (APPEAL NO. 2013-028)** be **SUSTAINED** and that the dismissal of the Appellant be rescinded, and that she be restored to her previous position as Patient Aide II, or a position of like pay and status. The Board further **ORDERS** that Appellant shall be awarded back pay and benefits pursuant to KRS 18A.095(22), and to otherwise be made whole. KRS 13B.120, KRS 18A.105, and 200 KAR 12:030.

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

COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2013-028

ASHLEY LEWIS **APPELLANT**

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

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

****

This matter came for an evidentiary hearing on August 28 and 30, 2013, at 28 Fountain Place, Frankfort, Kentucky, before E. Patrick Moores, Hearing Officer. The proceedings were recorded by audio/video equipment and were authorized by virtue of KRS Chapter 18A.

The Appellant, Ashley Lewis, was present and represented by Hon. Michael L. Boylan, of Louisville, Kentucky. The Appellee, Cabinet for Health and Family Services (hereinafter "CHFS"), was represented by the Hon. Jennifer Wolsing, Assistant Counsel for the CHFS, Office of Legal Services, Frankfort, Kentucky.

I. STATEMENT OF THE CASE

1. **Ashley Lewis** appeals her employer's decision on January 28, 2013, to terminate her from the position as a Patient Aide II with the CHFS Department for Behavioral Health, Developmental and Intellectual Disabilities, where she was assigned to the facility at Bingham Gardens.

2. The dismissal appealed by Ms. Lewis was based on Lack of Good Behavior and Unsatisfactory Performance of Duties, pursuant to KRS 18A.095 and 101 KAR 1:345, Section 1, for the reason of violating Bingham Gardens' Operational Practice policies #OP 200.02.3, Employee Conduct; #OP 300.02.1, Conduct Between Staff and Residents; #OP 300.04.1, Resident/Client Rights; #OP 500.02.5, Dining Plans; and CHFS Personnel Procedure 2.1, Employee Conduct.

3. The Appellant, Lewis, was sent written notice from Howard J. Klein, Appointing Authority and Director of the Division of Employment, Office of Human Resource Management of the CHFS Cabinet, of her termination as a result of findings from an expanded investigation by Bingham Gardens into an incident on or about October 3, 2012, that Ms. Lewis withheld, denied, discarded and diluted fluids, and withheld specific food items from a resident patient, contrary to the resident's dining plan and the fact that there were no doctor's orders to do so.

4. Lewis' appeal was timely filed with the Kentucky Personnel Board on February 4, 2013, in which she disputed the allegations against her. A Pre-Hearing Conference was held on March 11, 2013, and the matter was scheduled for an evidentiary hearing to be held on August 28 and 30, 2013. The issue presented was whether the disciplinary action taken by the Cabinet against Lewis was neither excessive nor erroneous and was taken with just cause. The Appellee Cabinet had the burden of proof.

5. The evidentiary hearing was conducted on August 28, 2013, and continued on August 30, 2013. Following the initiation of the hearing, leading up to the first break in receiving testimony at 11:45 a.m., it was discovered that the audio/visual equipment had not properly been turned on by the Hearing Officer. After a discussion, it was agreed among the parties that the Hearing Officer would document the factual evidence presented as recorded in his notes, and that the parties would then have the opportunity to make any corrections, additions or deletions to the documentation of the evidence they deemed appropriate, which, upon agreement between the parties, would then be incorporated into the official Statement of Factual Evidence in the record.

6. Corrections were submitted by the Appellee and filed on the record on September 16, 2013. None were received from the Appellant. Said corrections from the Appellee did not include any substantive issues of evidence that had been excluded, but instead focused on the identification of a witness, and some points of grammar and punctuation.

II. STATEMENT OF FACTUAL EVIDENCE PRESENTED

1. The first witness for the Cabinet was **Soliah Nelson**, a former Direct Support Professional (DSP) and Lewis's coworker in the residence facility where Ms. Lewis worked. The testimony of Ms. Nelson was presented by telephonic conference. Ms. Nelson worked for the Cabinet at Bingham Gardens from May 2011 until December 2012, and she is now employed as a mental health worker in a Community Options care facility in Dallas, Texas.

2. Nelson testified that when she was hired to work at Bingham Gardens, she received two weeks of training as a DSP, and then was assigned to work in Residence Home #6, where Ms. Lewis also worked as the DSP charged as the caregiver for a resident patient [hereinafter identified as Resident #1]. She stated that on October 3, 2012, she observed Ms. Lewis take the orange juice of Resident #1 and pour out half and dilute his juice with water, and that she saw her take his coffee and do the same thing. She testified that when she asked Lewis why she was doing the dilution of Resident #1's juice and coffee, she replied that Resident #1 was to undergo an EEG that day, and did not need to have so much acidic fluids in him, and that the juice made him urinate more often.

3. Ms. Nelson stated that she occasionally took Resident #1 to McDonalds or Subway for lunch to obtain a sandwich according to a list of foods he could have as written by Ms. Lewis. She stated that the list of food he could have was written by Ms. Lewis and that his sandwiches had to be without mustard, which she alleged Ms. Lewis told her that mustard was not good for Resident #1. She testified that she later tried to discuss the matter of Resident #1's meal plan, and she learned that the dietician was on maternity leave. She was able to discuss the diet list with Resident #1's speech therapist, and that when she tried to discuss it with Lewis, she grabbed it from her.

4. Ms. Nelson stated that there were a number of complaints among the staff over the fact that Ms. Lewis was a "preferred" DSP to work one-on-one only with Resident #1. However, Nelson denied having any conflicts with Ms. Lewis. She stated that she was not aware of any disability of Ms. Lewis or limitations on her ability to work. However, she also stated that Lewis told her that she had a bad back condition and that she was told by her doctor to only work a shift of eight hours.

5. Ms. Nelson acknowledged that she also had been previously charged with disciplinary action and removed from duty for negligent treatment of a resident. She said this happened a week or two prior to the incident charged against Lewis, but that the allegations were not substantiated.

6. **Sharon Spencer** is employed as a DSP at Bingham Gardens, where she has been employed for the past one-and-a-half years. She described her duties as assisting the resident patients with their daily living activities, personal hygiene and nutrition needs. She was assigned to residents in home #6, which housed four residents, and was a coworker with Ms. Lewis. Ms. Spencer testified that Resident #1 had Ms. Lewis as his "preferred" DSP. She stated this created some complaints among her coworkers that Lewis only had one resident patient to work with.

7. Spencer testified that she had observed Lewis throw away Resident #1's prepared meal and make something else for him, and pour out most of his juice drink and refill the glass with water. She testified that she did not report what she had observed until she was approached by an investigator, and that she then wrote a statement that was introduced in the record. In that statement, Spencer wrote that she believed that Lewis had been his DSP for so long that Resident #1 would only listen to her and would eat only what she approved. Spencer added that looking back on events, she speculated that Resident #1 may have been intimidated by Ms. Lewis into doing whatever she directed.

8. **Ron Cooper** is the Director of Human Resources at Bingham Gardens. He testified that the DSP provides goods and services to the resident patients according to the Individual Life Plan (ILP) that is prepared for each resident, which directs the nutrition, medication and activity the resident is to receive on a daily basis. Cooper introduced several Operational Procedures regulations of Bingham Gardens that were to be followed concerning the treatment and care of the residents. He also introduced the record of Ms. Lewis' training while employed at Bingham Gardens, putting emphasis on the training she received of resident rights,

abuse and neglect, and the required conduct of the staff with the residents. The accuracy of the training record was satisfactory to Cooper, as it was a compilation from data provided by the facility's staff development training department, and was verifiable from information provided by sign-in sheets that shows the employees that attended the training, the date given, the name of the instructor, and the subject matter of the training. He added that access to the data base was restricted, and that no one had the authority to delete the recorded data in the training record. Cooper added that the employees are repeatedly retrained in the matter of staff conduct regarding the residents, and that the employees are provided copies of the Operational Procedures when they undergo the training, and the OPs are maintained in his office and in the office of Administrative Services and readily available to the employees.

9. Cooper noted that Lewis was the "preferred provider" for Resident #1, who was described as mentally challenged and sight-impaired as to be legally blind. Due to his condition, Resident #1 had input in his treatment, but did not have the final say. Resident #1's treatment was directed by his ILP, which included his daily "dining plan." The ILP dining plan is based on the assessments of the dietician, medical director, doctor, and speech pathologist, with input from the patient. Cooper stated that upon receiving the complaints of Lewis' conduct regarding Resident #1, the matter was reported to the facility's Risk Management team and to the Office of the Inspector General (OIG). The facility's Risk Management team investigated the matter and substantiated that violations of the Operational Practices had occurred. He said the IG inspection looked more at the facility and whether it was in compliance with the practices of its procedural operations, and not at the conduct of Ms. Lewis. The violations of Ms. Lewis was more closely reviewed by the facility's Risk Management Team, which found she had violated the resident patient's rights and meal plans, and did not exhibit honesty toward the resident.

10. Cooper testified that any changes to a resident patient's nutrition plan has to be specifically under the direction of the dietician, with the consultation of the speech pathologist to determine if there are any swallowing issues that will be affected by a change in the diet. Cooper testified that a DSP change to the resident's diet without being approved by the dietician is strictly not allowed. The DSP cannot on her own alter the nutrition, including liquids, to be provided the resident.

11. Cooper testified that he was not involved in the decision to terminate Ms. Lewis. He testified that the internal investigation by Risk Management was expanded on the OIG investigation due to the allegations that had been reported. He could not recall who provided the initial report that led to the expanded investigation. He said there were a lot of questions about the incident that Risk Management wanted answered. Ms. Lewis was removed from her direct care duties while the investigation was pending. Cooper said because the allegations of abuse and neglect were substantiated he drafted the request for major disciplinary action to Mr. Klein, which the Facility Director signed. He stated that he did not recommend or suggest disciplinary action, and that he did not discuss discipline with Mr. Klein. He testified that he did meet with Ms. Lewis to notify her of the reason for the Request for Major Disciplinary Action, which he read to her and said that she was provided two days to submit a rebuttal. He said that a substantiated allegation of abuse or neglect will generate a request for major disciplinary action,

as the facility has a zero tolerance policy.

12. **Vickie Fenwick** is a Program Investigative Officer 2 for the Bingham Gardens facility, which she has served for two years. Prior to her being assigned as an investigator, she was a trainer, which included "root cause analysis." Her duties were to investigate abuse and neglect allegations by gathering evidence and summarizing the evidence, interview witnesses, and make conclusions. She investigated the allegations against Ms. Lewis in response to a request from Risk Management. She introduced witness statements obtained from Donna Davis (an RN), Josephine Morris, Soliah Nelson and Sharon Spencer.

13. As a result of her investigation, Ms. Fenwick submitted a "Final Expanded Investigative Report," [Appellee Exhibit 15] summarizing her investigation into the allegations against Ms. Lewis, which she testified about at the hearing. Fenwick said that Soliah Nelson was the individual who reported the incident to Tommy Burden, the Speech Pathologist, who reported it to Risk Management. Based on witness statements that substantiated the allegations against Lewis, it was determined that Lewis had reduced the Resident's fluids, which led to the determination of abuse and neglect by Lewis.

14. Fenwick testified that the Documentary Evidence section of the report showed that Resident #1's fluid intake was lower. The report states:

> According to the Nursing Care Plan of #1 Resident, he is at risk for the following: Fluid Volume Deficit, Aspiration, and Skin Integrity.
>
> According to the Dietician Assessment dated 3/21/12, it was recommended that #1 Resident receive at least 8 8-ounce glasses of water daily. The assessment further states that #1 is to receive up to 2100mi (millimeters) of fluid daily.
>
> When reviewing the Food and Fluid Sheet for #1 Resident, for the month of September, it was noted that on the days that Ashley Lewis, DSP, is his assigned staff that it appears that he receives fewer amounts of fluids. There also appears to be an issue with how fluids are to be tabulated to ensure that the resident receives the daily recommended fluid requirement.
>
> According to the Treatment Administration Record (TAR), daily intake, oral intake is to be documented on treatment sheets located in the Lifebook. In her Witness Statement, Donna Davis, RN, stated that any information comes from the DSP (Direct Support Professional) and unless there is a physician's order for monitoring intake and output that this is not tracked by Nursing.
>
> (Final Expanded Investigative Report, Appellee's Exhibit 15, page 8.)

15. Fenwick testified that it was "neglect" of the resident if the reduction of the fluids and food are not part of the ILP. Fenwick interviewed Lewis, who told him that Resident #1 didn't like water because he said it didn't taste good, and that he would get mad or rushed and spill his drink, and that that it caused him to void 3 to 7 times a day on her shift. Additionally, it was disclosed that Resident #1 also had diarrhea problems after going to McDonald's Restaurant. Fenwick concluded in her report:

> Based on the preponderance of evidence, it is substantiated that Ashley Lewis, DSP, denied #1 Resident, fluids.
>
> According to the Witness Statements of DSPs Josephine Morris and Soliah Nelson, they witnessed Ashley Lewis, DSP, diluting #1's orange juice with water, as well as pouring out the majority of his coffee. Ms. Morris in her testimony stated that she witnessed this incident on September 19, 2012, and Ms. Nelson witnessed the same type incident on the morning of October 3, 2012. This type of activity was also noted to be observed in the past by Sharon Spencer, DSP, although she could not provide an exact date as to when this had occurred.
>
> In her testimony, Dr. Vance has written no orders regarding the restriction, nor to have orange juice diluted. . .
>
> (Appellee's Exhibit 15, page 9)

16. Fenwick testified that based on the witness statements and documentary evidence, everything pointed to occurrences of abuse and neglect. Fenwick further testified that there was no clinical evidence of malnutrition or dehydration, and she acknowledged that Resident #1 did not appear neglected or malnourished or dehydrated. However, she testified there were still sufficient findings of abuse and neglect. Fenwick stated that Bingham Gardens Operational Practice guidelines at OP-1000.02.6 require that an incident report shall be made when certain incidents are witnessed, including "neglect," defined as "a situation in which an adult is unable to perform or obtain for himself the goods or services that are necessary to maintain his/her health or welfare, or the deprivation of services by a caretaker, i.e., the failure to provide goods and services necessary, to maintain the health and welfare of an adult, which may result in physical harm, mental anguish, or mental illness." Fenwick said that Resident #1 is visually impaired and presents a situation where he is unable to attend nutrition for himself, or do some other things for his own welfare, without assistance of his caregiver. Fenwick testified that there was no finding of physical neglect because there was no endangerment to Resident #1's welfare, or finding of malnourishment or dehydration. However, by limiting his food and watering down his liquids, without his knowledge, such conduct constituted neglect. Fenwick presented the evidence and her findings in her Final Expanded Investigative Report to the Risk Committee; however, in her conclusion she made no recommendation for further investigative action and disciplinary action.

17. **Howard J. Klein** is the Cabinet's appointing authority and Director of the Cabinet's Division of Employment, and it was in this capacity that he approved the termination of Lewis and signed the letter giving her notice of her termination. He described Bingham Gardens as an "intermediate care" facility. He testified that if the OIG sees any neglect in these facilities under the Cabinet's control, it forces their hand if substantiated. He stated if there is a failure to act on the findings of denied foods or dilution of fluids, and that if the employee is still there, the Cabinet could lose its Federal funding. He described the termination of Lewis was the only corrective action they could take, as Federal regulations say the Cabinet cannot employ someone with a history of neglect. Klein testified that the Cabinet had experienced other cases of corrective actions dealing with abuse and neglect that resulted in dismissal of staff, citing previous incidents at Hazelwood, and Oakwood, the latter having actually lost its Federal funding.

18. Mr. Klein said the initial draft of the termination letter was prepared by his staff member, Jennifer Young, who works on disciplinary actions, and was reviewed by legal and the EEO sections. He stated that he listened to Ms. Lewis "give her story" in a pre-termination hearing, and that he read the witness statements provided in the packet he received. He testified that he has to rely on the facility's report submitted to him, plus the staff recommendation. He recalled that there was no finding of dehydration or malnourishment, but what mattered was the requirement in the resident's ILP with the doctor's and dietician's determination of what the nourishment and fluids the resident should have. The investigation found that Resident #1 was denied fluids, and that the detriment to the patient's health is an ongoing concern. As a result he made the final determination to terminate Ms. Lewis.

19. **Karen Henderson** is the Facility Manager at Bingham Gardens and the Director of the Risk Management Committee, and has served the Commonwealth in this capacity since March 2012. She has worked for more than twenty years in the mental health care services provided by the Commonwealth. This has included serving as a certified investigator in the Cabinet of neglect and patient rights issues, and that she has been involved in writing policies concerning these issues within the Cabinet.

20. Henderson testified that in August of 2012, she was involved in retraining Lewis regarding abuse and neglect and the facility's Zero Tolerance Policy, the definition of abuse and exploitation of patients and completing Incident Reports. She added that every month they have to meet with staff and review the abuse policy, and that every employee has to sign off on the Zero Tolerance Policy. Henderson testified that it is repeatedly made clear to all staff that the facility will not tolerant any abuse, and that Lewis appeared to understand the Zero Tolerance Policy. She said that every employee, including Lewis, received the full training program on patient abuse and neglect. Henderson introduced a document (Appellee's Exhibit 16) showing that on August 21, 2012, she had provided training to Lewis on Incident Reporting and the policy concerning "Zero Tolerance for Resident Abuse," which Ms. Lewis signed acknowledging that she received a copy of the policy, that she read it, and that she understood it.

21. Henderson testified about requiring the investigation done into the alleged abuses of Resident #1, as she wanted to make sure they were substantiated. She said the facility has dieticians, nurses, doctors and therapists all involved in the formulation of the patients' meal plans and needs. She said it is mandatory that the ILP has to be followed as written by the entire staff, who are trained on operating according to the ILP, and are charged with looking after the full welfare of the patient. She said the resident can request changes, but that they have to be told that any request will be required to be brought to the properly authorized persons and an informed decision has to be made before any change is authorized. She added that it is facility policy that they do not force food or fluids on the residents. She added that any DSP thinking that a beverage is contributing factor to problems with a patient, has to consult with the appropriate authority and she should not make an arbitrary decision changing the requirements of the ILP.

22. Henderson testified that this was not a physical injury or physical harm case, but was concerning the area of neglect. She said that the staff is constantly being trained on a monthly refresher and updating basis and that Lewis was fully trained on what constituted abuse and neglect. Henderson testified that the purpose of the repetitive training was to provide the staff with clear understanding of the facility's policy, and when how and what reporting was required.

23. The Appellant, **Ashley Lewis**, served at Bingham Garden, as a Patient Aide II. She was hired in August 2010 at Bingham Gardens to provide care for residents and assist them in their daily activities, and acknowledged that she was trained in the facility's Zero Tolerance Policy for abuse of patients. (Testimony Video, 8/30/13; 11:12:01.) From day one she started her job, she served as the DSP Patient Aide to Resident #1, whom she described as being in his 60's, generally confined to a wheel chair, adding that he could walk with assistance, that he was legally blind, and that he had to be assisted with his toilet and bathing activities. She said that he had no teeth and was hard to understand. She described that he had an obsessive compulsive disorder, that trust was a big deal with him, and that from her first day on the job it took a lot of effort for her to gain his trust. She testified that over time she became his "preferred staff" attendant, adding that it took almost six months of her working with him, getting punched by him and having things thrown at her by him, before she gained his trust. She said he required a lot of coaching and prompting just to get him out of bed, described his eating habits as liking things prepared a certain way, and that his fluids had to be portioned, due to the fact that if he was given more than a half-full drink he would spill it. She said she never diluted his fluids as he would not drink it diluted. She said he drank cola, Kool-Aid, Crystal Light and fruit juices. She testified that if he was given a food he did not like, he would not eat it. She testified that if he wanted something else, she would have to get approval before she could give it to him. She said his diet plan changed quite regularly, particularly concerning his meat intake. Some foods he would not eat as he had no teeth and it was difficult for his to chew anything hard textured. She described the foods he liked and said he was a "dessert fanatic."

24. Ms. Lewis worked from 6:45 a.m. to 3:15 p.m. She denied the allegations made by Ms. Nelson, stating that she never diluted the Resident #1's juice or coffee, nor denied him water. She said that he enjoyed drinking these fluids, but if he refused to eat anything there was no way she could force him to eat it. His diet plan allowed for alternative foods, which were available in the residence house, which she would prepare for him. She said if he asked for something that was not on his diet list, she would have to take the request to the nurse. They would take him and other residents to McDonalds, but she said if he ate greasy food or drank a lot of soft drinks, he began to experience diarrhea. The pattern of diarrhea was documented to the extent it was decided in a team meeting to not allow him to go to McDonald's.

25. Ms. Lewis alleged that Ms. Nelson had a motive for making the charge against her, stating that she would have gained personally from Lewis being removed as the DSP for Resident #1, as she had repeatedly complained to her supervisor about how unfair Lewis' assignment to one resident was to the other DSPs. On one occasion Nelson had filed a discrimination complaint against Lewis. Additionally, Nelson was a temporary employee, and Lewis questioned Nelson's ability to witness the incidents she alleged, as the patient she was assigned was in a separate room in the residence house. Ms. Lewis denied she did any acts of abuse or neglect to Resident #1, and asked what reason would she have to dilute or deny him food or liquid. She raised a question as to what reason would she throw out his food or dilute his liquids. She said it would be stupid to deny him liquids in order to prevent his frequent need to go to the bathroom, as he was always able to indicate when he needed to go to the toilet, and that it was much easier to assist his going to the toilet than having to change his clothes if he urinated in his pants.

26. Lewis testified about having suffered an on-the-job injury in 2012 and while on workers' comp during May to August, she was on pain medication and that she was forced to return to work on limited duty. She testified that she was confined to a small office, alleging that she was "harassed" to write up 52 pages of dotted numbers and letters, and then she was directed to record employee training records into the computer.

27. Lewis said that she learned of the charge against her about the liquids denied to Resident #1 on October 4, when Karen Cline notified her that she was pulled from her assignment. She was directed to meet with Sheila Miles and Raleigh Richardson, who sat her down and read the disciplinary charge against her and asked her to sign the document. Lewis testified that she requested an opportunity to read the charges, which they refused, following which Lewis refused to sign the document of charges read to her. Lewis further said that she told them she did nothing wrong. She later met with Miles and Mr. Cooper, where they went over the major disciplinary action against her, and she said she tried to tell them the allegations against her were wrong. She said she was not allowed to talk, and was repeatedly told to write out her rebuttal to the charges and to submit them. She said she was not allowed to talk to anyone in HR on a one-to-one basis, and she was told by Cooper that she could not write her rebuttal while she was on the clock. Lewis said she was told by the OIG why she was being investigated, and that she wrote a denial of those charges, however, she was unable to produce a

copy. She completely denied the allegations by Nelson and Spencer that she had diluted his liquids.

28. Lewis raised questions about the facility's training on zero tolerance for neglect, challenging the accuracy of the Training Record produced by the Cabinet. She said the training record did not adequately show what her was training was. She said that she was never given a copy of the policies to take home, but that they always had to leave behind the copies used in training for the next class. Lewis further alleged that Sharon Spencer was "paid to come here to lie," and added that Spencer and Nelson collaborated to give false testimony against her. Lewis also said that Resident #1 could be brought to the hearing and given a drink of water and he would not drink it.

29. **Todd McGuire** is employed at Bingham Gardens as a Therapeutic Program Supervisory Assistant (TPSA). He described his duties as basically a "floor supervisor" over the staff assigned to a house of residents. He knew Ashley Lewis as one of his employees, and that even though he was her front-line supervisor, he was told by his supervisor that he could have no input in the OIG investigation of the allegations against Lewis.

30. McGuire testified that he was often required to train Lewis and the other staff he was responsible for supervising, but this often presented a problem as he did not even have the training himself. He said he would tell this to his supervisors, who would often respond that they also did not have the training. McGuire also stated that he would often drive Resident #1 on the outings for lunch at McDonald's or Subway, and he described that Resident #1 always got the same food items every time. McGuire also said that Resident #1 did not like to drink water.

31. McGuire testified that several employees were constantly complaining to him, and to other supervisors, about Lewis having a one-on-one assignment working with Resident #1, when they would have to work with several residents. He described the employees involved in the complaining were Sharon Spencer, Soliah Nelson, Myra Moffett, and Josephine Morris. He said they never complained about the treatment given the resident by Lewis, but that they would voice complaints at least three days a week about how they considered it "unfair" that Lewis only had to work with one resident. He said he observed Ms. Nelson be very rude towards Lewis, yell at her, and snatch things out of Lewis' hand. He also overheard Nelson talking to the other DSP's and staff saying bad things about Lewis. McGuire also stated that the relationship between Ms. Spencer and Lewis was bad. As a result of Nelson's conduct towards Lewis, McGuire asked his supervisor for permission to move Nelson to another residence, but his request was denied because they were too short-handed with the staff.

32. McGuire testified that after Lewis was removed from caring for Resident #1, the others on the staff didn't know how to take care of him and began experiencing difficulty providing daily care and assistance. McGuire testified that he started refusing his meals and taking his showers. McGuire said that on one occasion his supervisor told him to "lie" to Resident #1 that the liquid he was being given was something else besides water.

33. Concerning the training, McGuire denied that he was involved in any training of Lewis or other staff on conduct between staff and client, or conduct between staff and residents, or employee conduct, or abuse and neglect, or patient rights. He said that these topics were out of his responsibility area.

34. **Abigail Shepherd** is currently employed as a mental health technician at Central State Hospital, an adult psychiatric hospital located in eastern Jefferson County, Kentucky. She previously worked at Bingham Gardens where she was hired in 2009 as a Qualified Mental Retardation Professional (QMRP). She testified that she was started as an one-on-one staff member with Resident #1, and later served as his case manager, and that she was replaced by Lewis when she moved on to another assignment. She stated that Resident #1 was very opinionated and always wanted to know exactly what was in front of him, and that he would often refuse to eat certain foods and drink certain fluids. Shepherd testified that Resident #1 would not drink water, saying to the staff support person, "I don't drink that!" Shepherd testified that Resident #1 was given medication with chocolate milk, and that he often would have bowel movements afterwards. As a result, he began to associate chocolate milk with medicine and bowel movements. He preferred to drink Kool-Aid with medication. She further stated that he would definitely recognize if his juices or coffee were watered down, or did not have the correct amount of sugar.

35. Shepherd testified that Resident #1 was very difficult to understand, stating that he was a resident that required the same person's care day after day. She had to spend a lot of time with him before she was able to understand what he was saying, and he was used to things being the way he wanted them. If she tried to get him to eat something he was refusing, she was required to utilize a lot of reinforcement to get him to agree to eat the food. She testified that he was often interviewed by his support team as to his likes, and that he had the right to refuse foods.

36. **William Daniel Pollard** is employed at Bingham Gardens as a Training Specialist II. He knew Appellant Lewis, having trained her and worked with her. He said that any worker on light duty would be assigned to enter data bringing the employee training records up to date. He testified that he would then go through the employee training records and that he noticed a lot of errors. He was not aware who made the errors. He also testified that tests used by Bingham Gardens to measure competency eventually had ceased to be given.

37. **Karen Cline** is the Director of Staff Development and training at Bingham Gardens. Her duties involve annual mandatory training, monitoring the training and entering in the employee data records the training they completed. She testified that when she took over the training department in July-August 2012, Lewis was at work in the department. Cline described Lewis as "wonderful," as she proctored the training examinations, grading most of the tests, found mistakes and developed answer keys. She described Lewis a "whiz" at data entry.

38. **Marsha Marcum** is a Qualified Intellectual Development Professional (QIDP) at Bingham Gardens, which involves the responsibility for all paperwork, authorizing the Individual Life Plan (ILP), conducting training of conduct between staff and residents. She stated that when she did training on the policies, copies were provided to the employees, and that she would cover each item in the policy one by one. She testified that the employees had the option to take the copies of the policy with them. She said the employees were tested at the end of the training, which she personally graded to insure accuracy and competency.

39. **Raleigh Richardson** is a HR Administration Coordinator at Bingham Gardens. He testified that the training concerning "employee conduct" involved the policy and procedures, together with explanations of the consequences for failure to comply with the policy, which includes disciplinary actions up to and including termination. He testified about one earlier incident that involved a charge against Lewis concerning a violation of the Employee Conduct policy regarding the use of a cell phone, but he was unaware if there was any disciplinary action taken against Lewis.

III. FINDINGS OF FACT

1. The Appellant, Ashley Lewis, began working at Bingham Gardens in August, 2010, as a Patient Aide II providing direct support to the patient/residents at the facility.

2. From her first day on the job at Bingham Gardens, Lewis was assigned to work on a one-on-one basis with Resident #1. It was clearly established by the evidence that Resident #1 was a legally blind and mentally, intellectually challenged man in his 60s, with no teeth and essentially confined to a wheel-chair, who had a strict Individual Life Plan (ILP) that required close monitoring of his dietary needs and liquids intake. He was difficult to understand and was very demanding. He often made difficult the ability of the direct support professional aide working with him in getting him to follow his dietary and liquid needs, among which was his refusal to eat certain foods and to drink water.

3. The one-to-one assignment in caring for Resident #1 was due to the demands and special needs of Resident #1. The care was not a special assignment or privilege given to Lewis, but had also been the assignment of Abigail Shepherd, who was directed to work with Resident #1 for almost two years prior to Lewis being hired by Bingham Gardens.

4. There was apparently some jealousy and resentment among Lewis' coworkers, who were bitter of her being assigned to one resident, while they would have to work with several. One of the supervisors, Todd McGuire, testified that he would hear complaints from Lewis' coworkers at least three days per week about the "unfairness" of this arrangement. He said that the complaints were especially noticeable from Sharon Spencer, Soliah Nelson, Myra Moffett and Josephine Morris, and that the attitude of Nelson towards Lewis became so bad that he tried to get Nelson assigned to another residence, which was refused by his supervisor due to the staff being short-handed.

5. A troubling aspect of this case centers on the facts presented into evidence that the allegations of abuse and neglect were raised by two of Lewis' coworkers, Soliah Nelson and Sharon Spencer, that her supervisor, Todd McGuire, described as continually complaining that Lewis was receiving unfair favoritism by being assigned to only one resident. However, the testimony of Lewis, her supervisor, and Abigail Shepherd, the staff person that proceeded her in the care of Resident #1, established on the record that Resident #1 was a person with an obsessive-compulsive disorder, with intellectual and visual disabilities and very special needs, who was difficult to work with and was very distrustful. The handling of this resident/patient required an ongoing one-on-one involvement by a staff direct support professional that was able to build that required trusting relationship. These coworkers, Nelson and Spencer, had an open personality conflict with Lewis that raises credibility issues concerning the veracity of their allegations. Compounding the issue of the reliability of the evidence was that Lewis' supervisor was instructed he could have no input in the investigation.

6. Equally troubling is the fact that the allegations made against Lewis were that she was "watering down" the liquids offered to Resident #1. The problem with this accusation was that the evidence of record established that he disliked drinking water, and could tell if his drink was watered down, and would refuse to drink it. Further, a troublesome question was raised by Lewis, that went unanswered, as to why she would dilute his drinks or throw away his food.

7. The Cabinet's decision to take the matter further for disciplinary action was the investigative findings that the accusations were substantiated by witnesses, by what Henderson described as 51% substantiation that the Resident #1's diet had been changed by Lewis.

8. Vickie Fenwick, who investigated the charges resulting in Lewis' termination, reported in her Final Expanded Investigative Report, that the allegation against Lewis of abuse and neglect in caring for Resident#1 was first raised by Soliah Nelson. On October 3, 2012, at 3:30 p.m., she reported the allegation to Tammy Burden, a Speech and Language Pathologist, that she had observed Lewis diluting Resident #1's orange juice and coffee with water. Burden in turn reported the incident to Karen Henderson, Risk Manager, that day at 4:20 p.m. By 4:25 p.m., Fenwick was assigned to conduct an expanded investigation into the matter. Within ten minutes, at 4:35 p.m., Lewis had been removed from direct care duties with Resident #1. The record is established that the facility acted promptly upon receiving notice of the allegation of neglect.

9. Fenwick interviewed and obtained statements from Lewis' coworkers, Soliah Nelson, Sharon Spencer and Josephine Morris, and from Donna Davis, an RN. She reported that Nelson and Spencer stated that they observed Lewis pour out part of Resident #1's juice and coffee, and replace it with water.

10. Bingham Gardens has a "zero tolerance" policy, which Karen Henderson described as meaning that the facility does not tolerate any abuse, and that every employee signs off on the policy. She produced a copy of the zero tolerance policy, which Ashley Lewis signed on August 12, 2012, acknowledging that she received a copy of the policy, and that she read it and understood it. (Appellee's Exhibit 16.)

11. There was no evidence presented that Resident #1 suffered any physical injury or harm, but was solely described by Karen Henderson as a matter of neglect and abuse. She acknowledged that there was no finding that Resident #1 was dehydrated or malnourished. However, the fact that Resident #1 was being denied his liquids was sufficient to constitute abuse and neglect under the facility's policies.

12. The Cabinet Director of the Division of Employment, Howard J. Klein, established that if an OIG investigation determines that neglect has occurred, the Cabinet's hand is forced. Klein testified that he had to depend on the facility to provide accurate reports, and the finding by the OIG substantiated that Resident #1 had been denied certain foods and given diluted fluids. Klein said that the Federal regulations prohibits them from employing anyone with a history of neglect, and if the OIG later finds that the employee that was involved in the violation is still working in the facility dealing with the needy residents, the Cabinet could lose its Federal funding. Klein testified that the fact there was no evidence that Resident #1 was dehydrated or malnourished did not matter, as the evidence pointed to an ongoing situation that could be detrimental to the patient's health. Klein testified that the investigation, primarily comprised of the witness statements, together with hearing Lewis give her statement at a pre-termination hearing, led him to make the decision to terminate Lewis.

13. Appellant Lewis raised an issue about the training she was alleged to have been given concerning the facility's neglect policies, questioning the accuracy of the Employee Training Records. However, sufficient evidence was presented from witnesses Karen Henderson, William Daniel Pollard, Karen Cline, Marsha Marcum and Raleigh Richardson concerning their involvement in the ongoing training of the staff, including Appellant Ashley Lewis, to establish that Lewis was sufficiently trained and aware that she did not have the discretion to deviate from the standard of care she had the duty to provide to the resident assigned to her care.

14. Furthermore, Lewis testified that she submitted a written rebuttal to the allegations against her, however, it was not presented into the record, nor were there any documentation she prepared recording any difficulties she was experiencing in getting Resident #1 to follow his dietary plan that required any deviations from the ILP's restrictive nourishment requirements.

IV. CONCLUSIONS OF LAW

1. The initial issue is whether the punishment meted out by the Cabinet meets the requirement of KRS 13B.150(2)(d) that the government agency's action is not "arbitrary, capricious, or characterized by abuse of discretion" and KRS 18A.095(1) requires that "a classified employee with status shall not be dismissed, demoted, suspended, or otherwise penalized except for cause."

2. Our Supreme Court has held that all of Kentucky's adjudications, whether judicial or administrative, are protected by due process guarantees whereby Kentucky citizens may be assured of fundamentally fair and unbiased procedures. *Commonwealth Natural Resources and Environmental Protection Cabinet v. Kentec Coal Co., Inc.*, 177 S.W.3d 718, 724 (Ky. 2005). Kentucky thus embraces the concept long ago enunciated by the United States Supreme Court that, in the exercise of its adjudicative authority, an administrative agency is not excused from adhering to the same basic principles of due process we expect of any court. *Morgan v. U.S.*, 304 U.S. 1, 22, 58 S.Ct. 773, 778 (1938), cited in *Osborne v. Bullitt County Bd. of Ed.*, 415 S.W.2d 607, 611 (Ky. 1967).

3. The record in this matter establishes that Resident #1 had ongoing issues with his food and drink. Lewis testified about the difficulties she experienced on a daily basis getting him to follow his dietary plan with food and drink. Also, Resident #1 began to experience diarrhea when he went to McDonald's and ate hamburgers. It was determined by the team providing care to Resident #1 that he should stop going to McDonald's. The investigation also reveals that the DSP had the duty to document on the record all issues dealing with the patient/resident. The record is persuasive that Lewis daily struggled with Resident #1's refusal to eat certain foods and take certain drinks. However, the record and evidence presented is void of any documentation of issues she was experiencing in getting him to follow his ILP, and any changes she made to preparing him alternative foods and drink. Such documentation, if any existed, was not presented into evidence. Nor was the written rebuttal that Lewis alleged she prepared and submitted in response to the charges against her.

4. Karen Henderson stated that a DSP thinking that a beverage is a contributing factor to a patient/resident's daily care problems, had a duty to consult with the appropriate authority, and that she should not make an arbitrary decision restricting his food or drink. By Lewis' own testimony, there were constant issues concerning the difficulty in having Resident #1 follow his dietary plan, but no documentation was provided showing that Lewis' actions were reported and were not arbitrarily made.

5. Bingham Gardens Operational Practices policy number OP-1000.02.6, defines neglect as: "A situation in which an adult is unable to perform or obtain for himself the goods or services that are necessary to maintain his/her health or welfare, or the deprivation of services by a caretaker . . ." There is no question from the evidence that Resident #1 fit the description of one who was "unable to perform or obtain for himself" and greatly was dependent on his DSP, and, as pointed out by Director Klein in his termination letter, Resident #1 was a risk for

dehydration.

6. Director Klein's testimony on the record pointed out the problems Lewis' alleged conduct was presenting to the government agency. 42 CFR § 441.585 sets forth the requirement for states and long term care facilities, that States must establish and maintain a comprehensive, continuous quality assurance system, described in the State's plan amendment, which includes the following: (1) A quality improvement strategy and (2) methods to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services. The evidence in the record established a pattern of problems with Resident #1, and alterations in his dietary plan compliance, that were acknowledged by Lewis. Unfortunately, the record is absent any evidence by Lewis that establishes the adherence to the ILP, or documented deviations discussed and approved by the appropriate authority.

7. The record establishes Bingham Garden's "zero tolerance policy," which is well known by all employees, and signed off by Lewis that she received and understood. Additionally, Mr. Klein testified about the requirements established by the Federal regulations they operate under, which unifies and reinforces the zero tolerance policy. The requirements at 42 CFR § 483.13: "Resident behavior and facility practices" states that the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, that the state must-

> (ii) Not employ individuals who have been-
> (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
> (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;

Klein testified that under these guidelines, together with the facility's zero tolerance policy, the Cabinet had no choice but to take the disciplinary action against Lewis.

8. KRS 13B.090(7) provides that the ultimate burden of persuasion in all administrative hearings is met by a preponderance of evidence in the record. The record contains sufficient evidence that the Appellant Ashley Lewis was the sole caregiver for Resident #1, that she experienced daily difficulties attending to his care, and that she was adequately trained and aware of the requirements to follow his ILP without deviation, unless approved by higher authority. The reasons for such restrictions are well reasoned and unnecessary to elaborate here. It is sufficient that evidence was presented, including the acknowledgments by the Appellant, that certain deviations were made in his diet plan, without authority and undocumented. Under the Cabinet's zero tolerance policy and the Federal regulations, the decision to terminate the Appellant was with just cause, and that the disciplinary action taken by the Cabinet of terminating Lewis was neither excessive nor erroneous.

V. RECOMMENDED ORDER

The Hearing Officer recommends to the Personnel Board that the appeal of **ASHLEY LEWIS VS. CABINET FOR HEALTH AND FAMILY SERVICES (APPEAL NO. 2013-028)** 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 E. Patrick Moores** this 19th day of November, 2013.

KENTUCKY PERSONNEL BOARD

MARK A. SIPEK
EXECUTIVE DIRECTOR

A copy hereof this day mailed to:

Hon. Michael L. Boylan
Hon. Jennifer Wolsing