A-2

STATE OF NEW JERSEY

In the Matter of Ineba Brownwest-Dunbar
New Jersey Veterans Memorial Home Menlo Park,
Department of Military and Veterans Affairs

CSC DKT. NO. 2014-1557
OAL DKT. NO. CSV 00318-14

FINAL ADMINISTRATIVE ACTION OF THE CIVIL SERVICE COMMISSION

ISSUED: September 17, 2014 **BW**

The appeal of Ineba Brownwest-Dunbar, Human Service Technician, New Jersey Veterans Memorial Home Menlo Park, Department of Military and Veterans Affairs, removal effective November 7, 2013, on charges, was heard by Administrative Law Judge Jesse H. Strauss, who rendered his initial decision on August 6, 2014. Exceptions and cross exceptions were filed.

Having considered the record and the Administrative Law Judge's initial decision, and having made an independent evaluation of the record, the Civil Service Commission, at its meeting on September 17, 2014, accepted and adopted the Findings of Fact and Conclusion as contained in the attached Administrative Law Judge's initial decision.

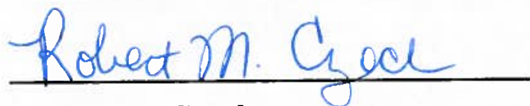
ORDER

The Civil Service Commission finds that the action of the appointing authority in removing the appellant was justified. The Commission therefore affirms that action and dismisses the appeal of Ineba Brownwest-Dunbar.

Re: Ineba Brownwest-Dunbar

This is the final administrative determination in this matter. Any further review should be pursued in a judicial forum.

DECISION RENDERED BY THE
CIVIL SERVICE COMMISSION ON
SEPTEMBER 17, 2014



Robert M. Czech
Chairperson
Civil Service Commission

Inquiries
and
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Henry Maurer
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attachment

State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NO. CSV 00318-14

2014-1557

IN THE MATTER OF INEBA BROWNWEST-DUNBAR, NEW JERSEY VETERANS MEMORIAL HOME MENLO PARK, DEPARTMENT OF MILITARY AND VETERANS AFFAIRS.

Ineba Brownwest-Dunbar, pro se

Christopher Hamner, Deputy Attorney General, for respondent New Jersey Veterans Memorial Home Menlo Park, Department of Military and Veterans Affairs (John J. Hoffman, Acting Attorney General of New Jersey, attorney)

Record Closed: July 21, 2014 Decided: August 6, 2014

BEFORE **JESSE H. STRAUSS**, ALJ:

STATEMENT OF THE CASE

New Jersey Veterans Memorial Home Menlo Park, Department of Military and Veterans Affairs (Home) removed Human Services Technician Ineba Brownwest-Dunbar (Dunbar) for alleging kicking a resident's wheel chair several times in order to impede her from returning to her room. At issue is whether Dunbar engaged in this conduct, and, if she did, whether her actions constitute (1) physical or mental abuse of

resident, D.B. or creating a disturbance under the Department of Military and Veterans Affairs Disciplinary Action Program; and (2) conduct unbecoming a public employee and/or neglect of duty in violation of N.J.A.C. 4A:2-2.2 and -2.3(a)(6) and (7).

PROCEDURAL HISTORY

On November 7, 2013, the Home served upon Dunbar an Amended Preliminary Notice of Disciplinary Action removing her at a date to be determined. After a departmental hearing, the Home issued a Final Notice of Disciplinary Action on November 21, 2013, removing Dunbar effective November 7, 2013. On December 5, 2013, she requested a hearing. The Civil Service Commission transmitted the case, pursuant to N.J.S.A. 52:14B-1 to -15 and N.J.S.A. 52:14F-1 to -13, to the Office of Administrative Law (OAL), where it was filed on January 9, 2013. I granted the Home's request to adjourn a scheduled April 23, 2014, hearing due to the unavailability of several witnesses.

I heard the matter on July 21, 2014, and the record was closed.

FACTUAL DISCUSSION

The Home is a long-term care facility for elderly veterans and spouses. The Home is divided into several units of a maximum of sixty residents, one of which is called the Freedom Unit. There are several other locked units for residents suffering from severe dementia. The Freedom Unit is not a locked unit. Residents are free to roam about the unit unless there is a medical order for restriction.

Dunbar had been a human services assistant (also known interchangeably as a certified nursing assistant (CNA)) since November 2007. On October 30, 2013, Dunbar worked the 3:00 p.m. to 11:00 p.m. shift in the Freedom Unit. At approximately 3:30 p.m. Dunbar was assigned to staff the T.V. room of the Unit. The room consists of several tables and chairs. Residents can engage in various activities, rest, or watch television. Many of the residents are wheelchair-bound, including D.B., who was in the

T.V. room that afternoon. There is a nurse's station or counter in front of the T.V. room affording a clear view of the room. (A-1.)

Registered Nurse Michelle Sanders has been a supervisor of nursing at the Home for eight years. Sanders testified that she was by the nurse's station at approximately 3:30 p.m. speaking to a resident. When she heard resident D.B. yelling out, "stop kicking me," she initially thought that two residents were having an altercation. However, when Sanders looked into the T.V. room over the waist-high wall of the nurse's station, she observed at a distance of approximately twelve feet that Dunbar was sitting in a chair at an angle to D.B.'s wheel chair, and they were about one foot apart. As D.B. was turning her wheel chair, Dunbar raised her leg and kicked the footrest of the wheel chair with enough force to propel it backwards. When D.B. again attempted to move her wheel chair forward as if to leave the T.V. room, Dunbar again kicked the footrest causing the wheelchair to move backwards. Dunbar repeated the action a third time. D.B. had her left foot on the footrest that Dunbar kicked, and she had her other foot on the floor. Sanders also testified that the resident to whom she had been speaking responded to the yelling and said, "see how they treat people here." She also heard another resident say, "she [D.B.] did not do anything wrong, yet she is crying." After observing the activity, Sanders instructed Dunbar to leave the T.V. room and directed the charge nurse to assign someone else to replace Dunbar there. Within one to two minutes of this observation, Sanders reported to Charge Nurse Judith Onday what she had seen. Onday confirmed that Sanders had given her the above rendition of what she had observed. Onday testified that although she did not observe the kicking incident, she saw a resident in the hallway by the nurse's station and T.V. room, yelling, "she kicked me. She kicked me." There was no bruising on D.B.

Upon discussing the T.V. room events after having Dunbar leave the area, Dunbar contended to Sanders that there was an order that D.B. not leave the T.V. room. Sanders testified that, typically, residents are allowed to roam throughout a unit.

Dunbar describes the interaction with D.B. on October 30 very differently. She was assigned to the T.V. room that day. D.B. was present with several other residents who were in chairs and wheelchairs. D.B. was known to roam all around the unit and

was constantly being pursued by staff. Because D.B. had previously fallen, she was not allowed to roam around the unit freely and was supposed to be kept in the T.V. room during the day. That day, D.B. kept wheeling to the hallway, and staff kept pulling her back to the T.V. room. When Dunbar arrived for her shift on October 30, the charge nurse assigned her to spend a one-hour rotation in the T.V. room. She instructed another staff member to take D.B. to the T.V. room as D.B. was then in the hall. In a moment D.B. again left the T.V. room for the hall; and Dunbar retrieved her. When Dunbar returned D.B. to the T.V. room, she sat down next to her at an angle to her wheelchair. Dunbar initially tried to redirect D.B.'s activities by bringing her water and some cookies. D.B. pushed her chair into a table upsetting some residents. When Dunbar resumed her seat, D.B. pushed another resident's chair as D.B. again attempted to move her wheelchair. Dunbar testified that, because she did not know how else to stop D.B. from leaving the room, she merely anchored her foot on the small wheel of D.B.'s wheelchair and put her hand on the back of D.B.'s chair. When D.B. calmed down, Dunbar removed her foot. When D.B. again turned and started to move her chair, Dunbar again anchored her foot and put her arm on the back of the wheelchair. Dunbar denied that she "kicked" the chair and testified that all Sanders could have seen was the movement of her foot to anchor the wheelchair. Dunbar also denied that D.B. yelled, "don't kick me." Dunbar also maintained that there is a difference between locking one's wheelchair, which is forbidden, and anchoring the wheel with one's foot to impede its movement.

Despite Dunbar's testimony that she attempted to impede D.B.'s ability to leave the T.V. room because of an order restricting her from roaming, none of the other witnesses called by either the Home or Dunbar confirmed such an order. Indeed, no one, including Dunbar, testified that anyone had specifically given an order restricting D.B.'s movement, and there was no evidence of a medical order in D.B.'s file restricting her movement.

Onday knew of no order that D.B. be kept in the T.V. room, and she was the charge nurse for the unit. Onday elaborated that staff knew that D.B. wanders and that they have to keep an eye on her, but that "we let her wheel around the unit." If D.B. were to leave the T.V. room, there were other staff members in the hallway and at the

nursing station to keep an eye on her. Onday described D.B. as having some confusion but basically alert. Sanders agreed as to the presence of some confusion, but that D.B. was capable of making her needs known. Onday testified that staff members are not allowed to restrict the movement of a resident's wheelchair with a foot or by locking it. That is unpermitted restraint.

Licensed Practical Nurse Faizy Moor assists D.B. in the Unit. She knew of no directive restricting D.B.'s ability to roam. If one needs to stop a resident there should be verbal redirection. Locking, kicking, or moving a wheelchair with one's foot is not allowed.

Licensed Practical Nurse Michael Gyamfi, assigned to the Freedom Unit, knew of no order restricting D.B. from roaming. If a wheelchair had to be stopped, a staff member would be able to do so using the handles on the chair.

Assistant Chief Operating Officer and Master's degree Registered Nurse Scott Mueller testified that he was not aware of any order restricting D.B. from roaming about the facility. If necessary, verbal redirection or holding a wheelchair's handle, rather than kicking, is an acceptable response to inappropriate behavior. Mueller further emphasized that, if any resident is to be restrained, there must be a physician's order on a CNA case plan. There was none here.

Nursing Assistant Olabisa Olowookere, testified. Although she could not say that D.B has dementia, she was often disoriented and tended to wander off. Because she had recently fallen while unattended, staff had wanted to keep D.B in the T.V. room so she would not roam and return to her room and possibly fall. Nevertheless, D.B. is allowed to move and wander around the unit in her wheelchair, but staff should know where she is. Because they are not allowed to lock the wheelchairs of residents, staff is supposed to verbally redirect a resident who tries to go where he or she should not.

CNA Nadia Frasilus testified that she replaced Dunbar in the T.V. room when Dunbar was relieved on October 30. D.B. was allowed to roam around, and Frasilus would not have objected if D.B. had wheeled herself out of the T.V. room.

For testimony to be believed, it must not only come from the mouth of a credible witness, but it also has to be credible in itself. It must elicit evidence that is from such common experience and observation that it can be approved as proper under the circumstances. See Spagnuolo v. Bonnet, 16 N.J. 546 (1954); Gallo v. Gallo, 66 N.J. Super. 1 (App. Div. 1961). A credibility determination requires an overall assessment of the witness's story in light of its rationality, internal consistency and the manner in which it "hangs together" with the other evidence. Carbo v. United States, 314 F.2d 718, 749 (9th Cir. 1963).

Sanders had no reason to fabricate a story. There was no showing of animus toward Dunbar. Sanders's testimony was clear and consistent and did not conflict with her written statement, which was made contemporaneously with the October 30 incident. It is credible testimony. Although both Sanders and Dunbar agree that Dunbar's foot did come into contact with D.B.'s chair, they disagree with the amount of force. If Dunbar was merely anchoring her foot against the front wheel, it is unlikely that the wheelchair would have been propelled backwards multiple times. Even if D.B. were somewhat disoriented, it is suspicious that she would have yelled out, "stop kicking me" if Dunbar had only anchored her foot against a wheel. Moreover, it is incredible that Dunbar denied that D.B. even made that cry when it was heard by Sanders, Onday, and the resident to whom Sanders had been speaking at the nurse's desk.[1] Dunbar's claim that there was some type of order that D.B. be kept in the T.V. room and not be allowed to roam freely is discredited not only by the Home's witnesses but by the witnesses called by Dunbar as well.

Accordingly, I make the following **FINDINGS** of critical **FACTS**:

In the afternoon of October 30, 2013, Dunbar kicked D.B.'s wheelchair three times with such force as to propel it backwards. Dunbar attempted to prevent D.B. from leaving the T.V. room even though there was no directive that D.B. not be allowed to roam freely throughout the Freedom Unit. In response to the kicking action of Dunbar,

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[1] Although the statement of the resident to Sanders is hearsay, it is admissible under the residuum rule as it corroborates Sanders's credible testimony. N.J.A.C. 1:1-15.5.

D.B. yelled that she should stop kicking her. Despite the kicking action against the wheelchair, there was no indication on D.B.'s body of physical abuse. D.B., however, expressed and exhibited anguish. There is no policy permitting a staff member to restrain the movement of a wheelchair-bound resident by kicking the wheelchair.

I further **FIND** that the Home maintains several policies regarding the treatment and rights of its residents and the consequences of improper employee conduct. The "Mandatory Resident Rights" statement of the Department provides that residents have the right to a dignified existence and self-determination and that all staff be trained in and responsible for complying with these rights. (R-5.) Residents are to be free from physical and mental abuse; to be free from physical restraints; and to be treated with courtesy, consideration, and respect for the resident's dignity and individuality. (R-5 at B. 5, 6, and 12.) The Home has its own "Policy Statement" that provides that residents must not be subjected to abuse by facility staff. (R-6.) This Policy Statement definition of abuse includes the willful infliction of unreasonable confinement, intimidation, or punishment with resulting mental anguish. It further defines physical abuse as including kicking, which may also include controlling behavior through corporal punishment. Mental abuse includes humiliation, harassment, and threats of deprivation. The Division also maintains a "Corrective and Disciplinary Action Booklet." (R-4.) The penalty for a first infraction of physical or mental abuse of a resident is removal. (R-4 at C-3.) This booklet further defines physical abuse as a physical act directed at a resident that could tend to cause anguish. Such acts include a resident being kicked. (R-4 at p. 18.)

Dunbar's prior disciplinary record consists of an August 30, 2011, Official Reprimand for causing a disturbance by arguing with another employee in the presence of a resident; an August 6, 2010, Official Reprimand for failure to carry out an order and being loud and argumentative with a charge nurse; and a five-day suspension for leaving her assigned work area without permission on July 19, 2012.

ANALYSIS AND LEGAL CONCLUSIONS

A civil service employee who commits a wrongful act related to his or her duties, or gives other just cause, may be subject to major discipline. N.J.S.A. 11A:2-6; N.J.S.A.

11A:2-20; N.J.A.C. 4A:2-2.2; N.J.A.C. 4A:2-2.3. In an appeal from such discipline, the appointing authority bears the burden of proving the charges upon which it relied by a preponderance of the competent, relevant and credible evidence. N.J.S.A. 11A:2-21; N.J.A.C. 4A:2-1.4(a); Atkinson v. Parsekian, 37 N.J. 143 (1962); In re Polk, 90 N.J. 550 (1982). The evidence must be such as to lead a reasonably cautious mind to a given conclusion. Bornstein v. Metro. Bottling Co., 26 N.J. 263 (1958). Therefore, the tribunal must "decide in favor of the party on whose side the weight of the evidence preponderates, and according to the reasonable probability of truth." Jackson v. Del., Lackawanna and W. R.R. Co., 111 N.J.L. 487, 490 (E. & A. 1933). For reasonable probability to exist, the evidence must be such as to "generate belief that the tendered hypothesis is in all human likelihood the fact." Loew v. Union Beach, 56 N.J. Super. 93, 104 (App. Div. 1959). Preponderance may also be described as the greater weight of credible evidence in the case, not necessarily dependent on the number of witnesses, but having the greater convincing power. State v. Lewis, 67 N.J. 47 (1975).

Dunbar has been charged with violation of policies of the Home regarding physical or mental abuse, creating a disturbance, and neglect of duty. The Home additionally charged her with conduct unbecoming a public employee and neglect of duty.

A public employee may be disciplined for "[c]onduct unbecoming a public employee." N.J.A.C. 4A:2-2.3(a)(6). "Conduct unbecoming a public employee" is an elastic phrase, which encompasses conduct that adversely affects the morale or efficiency of a governmental unit or that has a tendency to destroy public respect in the delivery of governmental services. Karins v. City of Atl. City, 152 N.J. 532, 554 (1998); see also In re Emmons, 63 NJ. Super. 136, 140 (App. Div. 1960). It is sufficient that the complained-of conduct and its attending circumstances "be such as to offend publicly accepted standards of decency." Karins, supra, 152 N.J. at 555 (quoting In re Zeber, 156 A.2d 821, 825 (1959)). Such misconduct need not necessarily "be predicated upon the violation of any particular rule or regulation, but may be based merely upon the violation of the implicit standard of good behavior which devolves upon one who stands in the public eye as an upholder of that which is morally and legally correct." Hartmann

v. Police Dep't of Ridgewood, 258 N.J. Super. 32, 40 (App. Div. 1992) (quoting Asbury Park v. Dep't of Civil Serv., 17 N.J. 419, 429 (1955)).

A public employee may also be disciplined for "neglect of duty." N.J.A.C. 4A:2-2.3(a)(7). Negligence is a failure to exercise the degree of care in a given circumstance, which a person of ordinary prudence would exercise under similar circumstances. See, e.g., Hempstead v. Rovinson, 1 N.J. 32, 34 (1948). Generally, the term "neglect" connotes a deviation from normal standards of conduct. In re Kerlin, 151 N.J. Super. 179, 186 (App. Div. 1977). "Duty" signifies conformance to "the legal standard of reasonable conduct in the light of the apparent risk." Wytupeck v. Camden, 25 N.J. 450, 461 (1957). Neglect of duty can arise from omission to perform a required duty as well as from misconduct or misdoing. Cf. State v. Dunphy, 19 N.J. 531, 534 (1955). Although the term "neglect of duty" is not further defined in N.J.A.C. 4A:2-2.3(a)(7), that infraction occurs when an employee has neglected to perform and act as required by his or her job title or was negligent in its discharge. A failure to perform duties required by one's public position is self evident as a basis for the imposition of a penalty in the absence of good cause for that failure.

I **CONCLUDE**, based on the preponderance of credible evidence, that Dunbar did neglect her duty to treat D.B. with dignity and respect. Such duty is clearly set forth in the policy statements of the Home.

I further **CONCLUDE** that, based on a preponderance of the credible evidence, Dunbar has engaged in conduct unbecoming a public employee. She expressed apparent impatience with D.B.'s repeated attempts to leave the T.V. room despite no directive or instruction that she was to restrain D.B. from freely roaming throughout the Freedom Unit. Notwithstanding no authority to restrain D.B. in any manner, Dunbar, nevertheless, did so by kicking D.B.'s wheel chair repeatedly as D.B. tried to exercise her privilege of departing the T.V. room. Such a manner of restraint was unprofessional in that other means were available such as grabbing the handles of the wheelchair. Although D.B. suffered from a degree of confusion, credible testimony established that she was alert and aware of her surroundings. Accordingly, Dunbar's conduct of improper restraint by physically kicking the wheelchair with sufficient force to propel it

backwards was humiliating and resulted in mental anguish by D.B. as evidenced by her reaction to Dunbar's conduct. Such conduct is more reprehensible when an employee such as Dunbar is charged with the duty to care for a universe of individuals who have a diminished capacity to care for themselves. Such employees have a heightened responsibility of forbearance when faced with frustrating situations created by challenged individuals. Dunbar breached that responsibility. Notwithstanding the lack of physical injury to D.B., Dunbar's conduct, nevertheless, strayed mightily from the standards expected of a CNA.

I **CONCLUDE** that the penalty of removal for Dunbar's offense against an elderly wheelchair-bound resident is appropriate.

ORDER

It is **ORDERED** that the penalty of removal of Ineba Brownwest-Dunbar by the appointing authority is hereby **AFFIRMED**.

It is further **ORDERED** that Brownwest-Dunbar's appeal be **DISMISSED.**

I hereby **FILE** my Initial Decision with the **CIVIL SERVICE COMMISSION** for consideration.

This recommended decision may be adopted, modified or rejected by the **CIVIL SERVICE COMMISSION**, which by law is authorized to make a final decision in this matter. If the Civil Service Commission does not adopt, modify or reject this decision within forty-five days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within thirteen days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the **DIRECTOR, DIVISION OF APPEALS AND REGULATORY AFFAIRS, UNIT H, CIVIL SERVICE COMMISSION, 44 South Clinton Avenue, P.O. Box 312, Trenton, New Jersey 08625-0312**, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

August 6, 2014

DATE

JESSE H. STRAUSS, ALJ

Date Received at Agency:

Date Mailed to Parties: AUG - 7 2014

DIRECTOR AND
CHIEF ADMINISTRATIVE LAW JUDGE

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APPENDIX

LIST OF WITNESSES

For Appellant:

Ineba Brownwest-Dunbar

Olabisa Olowookere

Nadia Frasilus

Rachel Varughese

For Respondent:

Michele Lee Sanders

Judith Onday

Faizy Moor

Michael Gyamfi

Scott Mueller

LIST OF EXHIBITS IN EVIDENCE

For Appellant:

A-1 Diagram of Freedom Unit

A-2 Statement of Michel Sanders, October 30, 2013

For Respondent:

R-1 Preliminary Notice of Disciplinary Action, November 7, 2013

R-2 Final Notice of Disciplinary Action, November 21, 2013

R-3 Prior Disciplinary Record

R-4 Corrective and Disciplinary Action Booklet

R-5 Mandatory Resident Rights Document

R-6 Policy Statement Document

R-7 Employee Information and Training Status, March 6, 2013