

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Andrea C. Roche, T. Scott Beck, Avery B. Wilkerson, Jr.
Workers' Compensation Commissioners

Tracking No. 2012-212326

WCC File No: 1103442

Gayla Ramey, Employee..... Appellant/Respondent

v.

Unihealth Post Acute Care Tanglewood, Employer, and
American Zurich Insurance Co., Carrier..... Respondents/Appellants

APPELLANTS' FINAL BRIEF

Respondents/Appellants

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STATEMENT OF ISSUES ON APPEAL

WHETHER CLAIMANT WAS ENTITLED TO TEMPORARY TOTAL DISABILITY BENEFITS?

WHETHER THE FINDINGS OF FACT AND CONCLUSIONS OF LAW DETERMINED BY THE APPELLATE PANEL WERE SUPPORTED BY SUBSTANTIAL EVIDENCE IN THE RECORD?

STATEMENT OF THE CASE

This claim arises out of an accident occurring on March 11, 2011, while Gayla Ramey (“Claimant”) was working for Unihealth Post Acute Care (“Employer”). Subsequent to her alleged injury, Claimant was terminated by Employer for falsifying paperwork in order to receive wages for time she was not at work. This claim was initially heard before Commissioner G. Bryan Lyndon on August 10, 2011, in Columbia, South Carolina. The Single Commissioner issued a Decision and Order on September 28, 2011 (R. p. 3), finding that Claimant sustained a compensable injury by accident on March 11, 2011, to her back and right upper extremity; was entitled to continuing temporary total disability compensation from March 24, 2011; and ordering the Employer to provide causally related medical treatment. An Appellate Panel of the South Carolina Workers’ Compensation Commission held a hearing on this matter on March 20, 2012, and issued a Decision and Order, dated May 23, 2012 (R. p. 17), affirming the Single Commissioner’s Findings of Fact and Rulings of Law in full and adopting the Single Commissioner’s September 28, 2011, Decision and Order as the Decision and Order of the Appellate Panel.

The primary issue before the Full Commission was whether or not Claimant was entitled to temporary total disability benefits from the date of her termination to the present and continuing. Claimant asserted that she was entitled to temporary total disability compensation as her termination by the employer is not tantamount to refusal of suitable employment. S.C. Code

Ann. §42-9-190. Defendants, however, argued that they fully accommodated Claimant's restrictions until she was released to full duty by her treating physician. After Claimant was released to full duty, Claimant was terminated for falsifying paperwork in contravention of company policy. Defendants argued that Claimant left work for a doctor's appointment without clocking out. When Claimant later submitted a time sheet correction form, she failed to deduct the time away from work from her submitted hours for that day. Employer terminated Claimant for this falsification in line with its company policy. Employer had terminated other employees based on similar acts in the past.

In his September 28, 2011 order, the Single Commissioner found that Claimant was entitled to temporary total disability benefits from March 24, 2011, the date of Claimant's termination, to the present and continuing. The Single Commissioner found that Claimant was a credible witness and that he did not believe that her failure to deduct the time for her medical appointment from her pay was done intentionally for the purpose of being deceitful, but was merely an error in procedure due to malfunction of the scanner that would typically be used to clock in and out. He found that the Employer led Claimant to believe that she would be paid for the time she was at her causally-related medical appointments.

Defendants thereafter filed for review of the Decision and Order of the Single Commissioner by the Appellate Panel of the Full Commission based on thirteen (13) exceptions. (R. p. 45). Defendants took exception to the Single Commissioner's findings and conclusions regarding the circumstances of Claimant's termination; whether Claimant's termination was justified; and whether Claimant's conduct was sufficient to bar Claimant from receiving temporary total disability benefits in accordance with S.C. Code Ann. §42-9-190. The Appellate Panel affirmed the Single Commissioner's Decision and Order and adopted his findings of fact and conclusions of law verbatim. This appeal followed.

STANDARD OF REVIEW

“The Administrative Procedures Act establishes the standard of review for decisions by the South Carolina Workers’ Compensation Commission.” *Forrest v. A.S. Price Mech.*, 373 S.C. 303, 306, 644 S.E.2d 784, 785 (Ct. App. 2007) (citing *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 134-35, 276 S.E.2d 304, 306 (1981)). “In workers’ compensation cases, the [Appellate Panel] is the ultimate fact finder.” *Shealy v. Aiken County*, 341 S.C. 448, 455, 535 S.E.2d 438, 442 (2000) (citation omitted). This court reviews facts based on the substantial evidence standard. *Thompson v. S.C. Steel Erectors*, 369 S.C. 606, 612, 632 S.E.2d 874, 877 (Ct. App. 2006). “Under the substantial evidence standard, the appellate court may not substitute its judgment for that of the [Appellate Panel] as to the weight of the evidence on questions of fact.” *Forrest*, 373 S.C. at 306, 644 S.E.2d at 785 (citing S.C. Code § 1-23-380(A)(5)). The appellate court may reverse or modify the Appellate Panel’s decision only if Claimant’s substantial rights have been prejudiced because the decision is affected by an error of law or is clearly erroneous in view of the reliable, probative, and substantial evidence in the record. *Id.* at 306, 644 S.E.2d at 785-86. “Substantial evidence is not a mere scintilla of evidence nor evidence viewed from one side, but such evidence, when the whole record is considered, as would allow reasonable minds to reach the conclusion the [Appellate Panel] reached.” *Shealy*, 341 S.C. at 455, 535 S.E.2d at 442. The possibility of drawing two inconsistent conclusions does not prevent the Appellate Panel’s conclusions from being supported by substantial evidence. *Tiller v. Nat’l Health Care Ctr.*, 334 S.C. 333, 338, 513 S.E.2d 843, 845 (1999). The final determination of witness credibility and the weight to be accorded evidence is reserved to the Appellate Panel. *Shealy*, 341 S.C. at 455, 535 S.E.2d at 442.

STATEMENT OF THE FACTS

At the hearing, Claimant testified on her own behalf. She testified that she is 50 years old and that she completed her Associate's Degree to obtain her RN. (R. p. 105, l. 25 – R. p. 106, l. 12) She explained that she received a scholarship from Employer in 2008 to go to nursing school. (R. p. 106, ll. 13-15) She also noted that she has further educational background prior to obtaining her RN degree. (R. p. 106, ll. 9-10) Claimant asserted that her job as an RN with the Employer involves administering treatment to residents and also includes activities like turning residents who are bedridden, assisting residents get in and out of beds and wheelchairs, and pushing wheelchairs to get residents from one part of the facility to another. (R. p. 106, l. 21 – R. p. 13, l. 1) She also stated that she did clerical duties such as medical charting and working with residents' family doctors to coordinate their care needs. (R. p. 107, ll. 1-4).

Claimant asserted that prior to the work accident she never had any problems with her back. (R. p. 107, ll. 5-7). She noted in 2008 that she was treated for muscle spasms in her right shoulder. (R. p. 107, ll. 8-11). She stated that she was having a lot of stress at the time and was having muscle spasms in the right shoulder. (R. p. 107, ll. 13-19). Claimant testified that she went to the doctor and received some steroid injections in the muscle and the spasms relaxed and the problem went away. (*Id.*). Claimant asserted that her previous problems were muscular only and not in her spine. (R. p. 107, ll. 20-24).

Claimant fell on some steps while at work on March 11, 2011. (R. p. 29). She testified that, immediately after her fall, she was sent to Doctor's Care for treatment. (R. p. 108, ll. 6-8). She testified that she had clocked-in that morning via hand-scanning device, but did not clock out when she was sent for treatment. (R. p. 108, ll. 1-11). She further stated that her understanding is that she was paid for her normal hours that day despite having to leave work to go to the doctor. (R. p. 108, ll. 12-14).

Claimant went on to testify that she was given work restrictions by the providers at Doctor's Care on that first visit. (R. p. 108, ll. 15-17). She stated that she was told not to spend more than 30 minutes per hour on her feet; to limit the use of her back; no use of her right arm; no lifting greater than ten pounds; and no repetitive bending, twisting, stooping, squatting, or pushing. (R. p. 108, ll. 18-24). Claimant asserted that she continued working as normal and her restrictions were not accommodated. (R. p. 108, l. 25 – R. p. 109, l. 2). She asserted that she was required to walk all over the facility, do a great deal of paperwork, pull charts from overhead to file forms, and sometimes she had to push residents in wheelchairs. (R. p. 109, ll. 6-13). Claimant stated that she felt that the tasks she was doing were in violation of her restrictions, but that she was scared of losing her job. (R. p. 109, ll. 14-17; R. p. 110, ll. 18-21).

Claimant testified regarding her March 18, 2011 appointment with Doctor's Care. Claimant stated that she had discussed her appointment previously with Lynda Burr, the facility Human Resources Director. (R. p. 111, ll. 2-4). She stated that she came in early that morning because she needed to see Ms. Burr about the appointment and knew that Ms. Burr was leaving early that day. (R. p. 111, ll. 4-12). Claimant stated that Ms. Burr was not at the facility by the time she had to leave to go to her appointment and she had to go ahead and leave without speaking to Ms. Burr. (R. p. 111, ll. 16-24).

Claimant asserted that she attempted to clock-out around 7:30 that morning using the hand scanner, but that the scanner would not work when she tried to use it. (R. p. 112, ll. 1-2). Claimant stated that she left without doing anything further to sign out because she needed to get to the appointment. She stated that she returned at 9:45 that morning, and was told to go home about 45 minutes later by her supervisor Tonya Shepherd because Ms. Shepherd wanted her to work the next two days. (R.p.1112, ll. 6-16). Claimant stated that when she returned from the doctor, she completed a Request for Missed Time form to note the time she missed that would

not be reflected on the punch clock due to the scanner malfunction. (R.p.113, ll. 11-14). She indicated on the form the time period of 7:00 a.m. to 10:30 a.m. and asserted that was meant to reflect her time missed for the appointment. (R. p.113, ll. 15-17). She stated that she got the form approved by her supervisors, Carrie Ray and Tonya Shepherd, and that both of those supervisors knew that she had an appointment that morning. (R. p. 113, ll. 18-22).

Claimant testified that on the day she was initially injured, she was not told to punch out before she was sent to the doctor. She further stated that she was paid her regular wages for the time that she left and went to the doctor on the date of her injury. (R. p. 113, ll. 4-10). Claimant testified that it was her understanding from those events that she would be paid for work time that she missed for appointments related to her work injury and that no one had advised her any differently. (*Id.*) Claimant asserted that neither Ms. Ray nor Ms. Shepherd indicated there was any problem when she asked for approval of her missed time form on March 18th. (R. p. 114, ll. 1-3).

Claimant stated that she was fired three days later on March 21, 2011. (R. p. 114, ll. 6-8). She explained that she was called to Lynda Burr's office and told that she was not allowed to be on the clock while she was out for a doctor's appointment and was terminated. (R. p. 114, ll. 11-14).

Claimant stated that since her termination from Employer, she has not been able to find work within her restrictions. (R. p. 115, l. 20 – R. p. 116, l. 48). She asserted that since she has not had any treatment she was afraid of doing something that would cause further injury. (*Id.*) Claimant asserted that in looking for work she has looked through newspapers to see if there are any available jobs within her restrictions. (R. p. 116, ll. 15-22).

On cross examination, Claimant was asked about the paperwork that she completed at the time of her injury. Claimant was shown a notice informing her that she would not be paid for

time spent at doctor's visits which she signed as part of her initial workers' compensation paperwork. (R. p. 117, l. 8 – R. p. 118, l. 23). Claimant admitted that she signed all of the paperwork that she was given, but she didn't actually read all of it closely. (*Id.*). Claimant recalled being told that she could use PTO time for medical appointments during the waiting period until workers' compensation insurance kicked in. (R. p. 119, ll. 9-20). Claimant confirmed that the appointment on the March 18th that led to her termination was in fact her third doctor's appointment regarding her work injury. (R. p. 119, l. 21 – R. p. 120, l. 1).

Claimant noted that she had been having problems with the hand scanner for several days prior to March 18th. (R. p. 120, ll. 5-8). She stated that she did not even try to clock in using the scanner that morning because there was a certain procedure that had to be done by Ms. Burr to fix it and that since Ms. Burr was not there, she didn't bother to try using the hand scanner. (R. p. 120, ll. 9-23). Claimant was read her time correction form whereupon she had written that she was correcting her time because the "clock would not accept punch" which indicated that she was requesting to be paid for the time indicated on the form. (R. p. 122, ll. 2-18). Claimant denied that as her intention and asserted that she was attempting to confirm missed time for a medical appointment. Claimant confirmed that she listed her time for the day of March 18th as 7:00 a.m. to 10:30 a.m. and that she had to complete the form because the hand scanner was not working, and agreed that she was listing that time period as her work hours for that day. (R. p. 124, ll. 8-19).

Claimant admitted that she has had to miss work for medical problems previously during the time she has been employed with the Employer. (R. p. 124, l. 19 – R. p. 125, l. 1). She confirmed that she had gallbladder surgery in 2007 and was also out for about a month when her mother passed away. (R. p. 125, ll. 1-10). Claimant noted that she did not get fired for those periods of missed time, and it was even after dealing with those issues that she was offered her

nursing school scholarship. (R. p. 125, ll. 9-13). She also admitted that there is at least one other person in the facility who has a workers' compensation claim and continues working on light duty. (R. p. 125, ll. 14-22). Claimant agreed that she was treated fairly up until the point that she was terminated. (R. p. 125, l. 23 – R. P. 126, l. 2).

Claimant went on to testify that on her initial visit to Doctor's Care that she reported that her right arm, mid back, neck, and "tail" where she had landed where hurting. (R. p. 126, ll. 17-19). Claimant was pointed to her own APA, page 109, reflecting that first where there is discussion of the right arm and back, but nothing regarding any neck complaints. (R. p. 126 – R. p. 128). She was also pointed to her return visit on March 14, 2011, where she reported to the providers at Doctor's Care that she was "very improved." There was no discussion of neck pain and no indication from Claimant that she was not capable of performing her job or that the defendant/employer was not complying with the work restrictions. Claimant was then directed to the report from March 18th, which was the first indication that she was experiencing neck pain, but again noted that there was improvement in her condition.

Claimant agreed that the doctor's restrictions did not prevent her from walking on the job, but merely indicated that she should not walk more than 30 minutes of each hour. (R. p. 129, ll. 11-23). She disagreed that it was primarily the duty of the CNA's to move the residents around the facility and that the nurses more so supervised the CNA's. (R. p. 130, ll. 7-12). Claimant admitted that she did not have to routinely do things like changing residents, but stated that it was in her job description. (R. p. 130, l. 15 – R. P. 131, l. 4). Claimant also agreed that the defendant/employer's facility is a no-lift facility and there are Hoyer lifts to help them move residents and the staff is required to obtain help before moving the residents. (R. p. 131, ll. 5-12). Claimant insisted that her job went well beyond assessing residents' medical conditions and administering medications. (R. p. 131, ll. 20-25). She insisted that she was required to do more

hands-on care tasks and was required to assist in “any and all” aspects of resident care. Claimant further asserted that, in her opinion, the facility was understaffed. (R. p. 132, ll. 2-8). She stated that the two CNA’s on the hall cannot see to all 40 residents at all times, so she did a lot of CNA duties. (R. p. 132, ll. 9-15).

Claimant admitted that her only efforts to find another job have been through looking at listing in the newspapers and on the internet. (R. p. 133, ll. 10-13). She admitted that she has not actually applied for any jobs. (R. p. 133, ll. 14-22). Claimant stated that based on the job descriptions that she feels that the jobs she has seen would be beyond her work restrictions, but she has not gone in person to inquire about the job duties. (R. p. 133, l. 23 – R. p. 134, l. 2).

Claimant was next questioned regarding her annual physical assessment with the Employer. She recalled going through the questionnaire from 2009 and indicating that she was taking some medication for swelling in her feet. (R. p. 135, ll. 12-25). Claimant was also read medical reports from her family doctor from December 2006 wherein she presented with complaints of neck pain and trapezius muscle tenderness. (R. p. 136, ll. 8-24). Claimant stated that she recalled only having muscle spasms, but did not recall the dates indicated in 2006. (I.). Claimant clarified from her prior testimony that she has had problems with muscle spasms on more than one occasion. (R. p. 138, l. 6). Claimant confirmed that she has not previously had an MRI of her cervical spine and did not know what was causing the muscle spasms. (R. p. 138, ll. 17-19).

On re-direct examination, Claimant asserted that she was released at full duty on March 18, 2011, because she asked to be. (R. p. 141, ll. 16-21). She asserted that she told the providers at Doctor’s Care that her arm felt better but that she was still having trouble with her back, but that she wanted to try being on full duty because she was needed at the facility. (R. p. 142, ll. 1-6). Claimant asserted that she did this because she was afraid that she would lose her job if she

did not get back to full duty. (R. p. 142, ll. 7-17). Claimant was again questioned about the March 18th report on re-cross examination. She insisted that she did not tell the doctor that she was 85% improved, as indicated in the report. (R. p. 143, l. 23 – R. p. 144, l. 5). Claimant also asserted that the statement on the work note that “she feels comfortable performing full work duties” was not entirely accurate and that she only requested to try her full duties. (R. p. 144, l. 17 – R. p. 145, l. 48).

The Commissioner questioned Claimant regarding the hand scanner. Claimant confirmed that it has malfunctioned in the past and would not accept her hand scan. (R. p. 147, ll. 18-20). She explained that she has always been paid when the hand scanner failed to work and that the procedure is to fill out a time correction form and have it approved by a supervisor to confirm that she was actually at work during the time indicated on the form. (R. p. 147, ll. 21-25). Claimant also confirmed that it is standard to punch out anytime she leaves the facility for any reason. (R. p. 148, ll. 1-6). Claimant stated that on the days prior to March 18, 2011, when the scanner was not working, that she clocked in and out manually and that she was in the facility during her entire shift those days performing her job duties as reflected on her manual time forms. Claimant also confirmed that the time form for March 18th only indicated that she worked and needed to be paid for the time indicated on the form, it did not specify that she had left for a doctor’s appointment at any point during the hours indicated on the form. (*Id.*)

Defendants called Lynda Burr to testify on their behalf. Ms. Burr is the Human Resources Director at the Tanglewood facility and has been in that position for nine years. (R. p. 155, l. 23 – R. p. 156, l. 1). Ms. Burr stated that her duties include the handling of all personnel records and any workers’ compensation claims in the facility. (R. p. 1156, ll. 8-10). She further confirmed that she was dealing with Claimant’s workers’ compensation claim. (R. p. 156, ll. 8-10). Ms. Burr stated that someone else, possibly Ms. Elkins the unit supervisor, arranged for

Claimant to go to the doctor for treatment on the date of the injury. (R. p. 1157, ll. 14-18). Ms. Burr talked to Claimant on subsequent occasions about her injury.

Ms. Burr explained that the facility works with injured employees to meet the needs of their individual restrictions. (R. p. 157, l. 23 – R. p. 158, l. 5). She noted that they do not create new jobs, but they often move people to other positions to suit their restrictions during light duty. Ms. Burr stated that it is policy to do everything possible to accommodate restrictions assigned by the doctors for injured employees.

Ms. Burr confirmed that she was involved in Claimant's termination. (R. p. 158, ll. 23-258). She explained that the hand scanner was not working for Claimant to clock in and out on the date in question, March 18, 2011. (R. p. 158, ll. 1-17). She stated that Claimant turned in a time correction form stating that she was present at work from 7:00 a.m. to 10:30 a.m. on that date. However, she later turned in a doctor's note reflecting that she was not present at work for part of the time indicated on the March 18th time form. The doctor's excuse and the time form were shown to the facility administrator, who made the decision that Claimant was to be terminated for falsifying her time sheet. (*Id.*).

Ms. Burr further confirmed that employees on workers' compensation are not paid for time that they leave work to attend doctor's appointments. (R. p. 159, ll. 18-22). She stated that workers are given a packet when injuries occur giving them all the procedural information and someone goes over the materials with the worker. (R. p. 159, l. 23 – R. p. 160, l. 4). She also confirmed that these materials include a notice to workers that they will not be paid for time during medical appointments. (R. p. 160, ll. 18-21). Ms. Burr confirmed that Ms. Elkins had gone over this paperwork with Claimant, but noted that in her subsequent conversations with Claimant that Claimant never asked any questions or expressed a lack of understanding of the materials that she was given.

Ms. Burr went on to testify that in the days following Claimant's injury, she never expressed any inability to perform her assigned tasks or expressed any concern about her restrictions not being properly met. (R. p. 161, l. 23 – R. p. 163, l. 22). She stated instead that Claimant only told her that she wanted to get back to work on the floor and that she was fine. Ms. Burr stated that she informed Claimant that she could not put her back to regular duty without a release to do so from her doctor. (R. p. 162, ll. 9-11). Ms. Burr noted that Claimant had restrictions against pushing so that she could not push the medication cart. (R. p. 162, ll. 13-14). She stated that the nursing supervisor had Claimant doing paperwork while she was on restricted duty. (R. p. 162, ll. 14-16). She further explained that she always advises employees with restrictions to self-monitor their activities to stay within their restrictions and if they are given a task that is outside their restrictions to come to her to adjust their duties. (R. p. 163, ll. 7-11). Ms. Burr testified that Claimant never complained about the modified duty that she was given. (R. p. 163, ll. 12-17). She stated that she received the release note from Doctor's Care noting Claimant felt comfortable performing her regular duties and stated that this note was consistent with Claimant's requests to her to be put back to full duty. (R. p. 163, l. 23 – R. p. 164, l. 14).

Ms. Burr next testified that the facility has terminated other employees for submitting false time requests. (R. p. 164, ll. 15-18). She estimated that it has happened about three to five times in the nine years that she has worked for Employer. (R. p. 164, ll. 19-21). Ms. Burr stated that falsification of any document is grounds for immediate termination per corporate policy, not just the policy of the facility. (R. p. 165, ll. 8-12). She explained that inconsistencies on the time sheet compared to other facility records create issues for the facility with DHEC and Medicare when the facility records are reviewed. (R. p. 165, ll. 5-7). She stated that all facility records must be accurate and consistent with one another. The Commissioner also questioned Ms. Burr

as to the nature of the falsification of records of the other employees who were fired for falsification of documents. Ms. Burr stated that several were terminated for falsifying time for entire shifts, but others were terminated for falsification of other records that were not related to time and pay. (R. p. 174, ll. 1-18). She also recalled that none of the other persons fired for record falsification had ongoing workers' compensation claims. (*Id.*)

The medical records reflect that Claimant initially sought treatment with Doctor's Care on March 11, 2011, on the date of her accident. Claimant reported that she slipped on some stairs and injured her right forearm, right hand, and her thoracic spine. Claimant presented with bruising and swelling in the right arm and hand, and bilateral paraspinal muscle pain in her mid back. (R. p. 342). Claimant was given restrictions of no lifting more than 10 pounds, no use of her right arm, limited use of her back, no standing for greater than 30 minutes per hour, and no repetitive bending/stooping/pushing/twisting. (R. p. 343).

Claimant next followed-up with Doctor's Care on March 14, 2011. Claimant reported feeling very improved with no pain in her right arm. The right arm contusion was noted to be healing with only mild ecchymosis, and she was reported to have only mild tenderness to palpation of the left paraspinal muscles. (R. p. 345). Her work restrictions were reduced to allow standing without restriction, pushing and twisting without restriction, and she was allowed full use of the right arm. (R. p. 346).

Claimant was seen again at Doctor's Care on March 18, 2011, reporting new complaints of right lateral neck and trapezius pulling sensation. (R. p. 348). It was noted that she otherwise denied complaints, that her mid-back felt 85% improved, and that there was no discomfort in the right upper extremity. On exam, Claimant was found to have mild tenderness in the right lateral cervical spine, but with full neck range of motion. It was noted that Claimant had no thoracic spine pain and no shoulder pain. (*Id.*). The work note provided on this visit noted Claimant's

mild cervical pain, but stated that she felt comfortable performing full work duties, thus she was given no restrictions. (R. p. 349).

Claimant next returned to Doctor's Care on March 24, 2011, three days after her termination, and was complaining of thirteen days of right shoulder pain radiating into her neck and back. (R. p. 350). On exam Claimant was noted to have a palpable muscle spasm in the right trapezius. Claimant's diagnosis was amended from a mid back strain and right arm contusion to that of muscle spasm, spondylolisthesis, and neck pain. She was referred for physical therapy and her work restrictions were amended to include limited use of her neck. These symptoms persisted on Claimant's follow-up visit on April 1st, and she complained of difficulty finding a comfortable sleeping position due to neck pain. (R. p. 355). She also was again found to have tenderness in her cervical spine and palpable muscle spasm.

Claimant was sent for a cervical spine MRI on April 4, 2011, which revealed evidence of chronic degenerative changes and a left disc protrusion at C3-4 and some spurring from C3 to C6. (R. p. 363). Claimant went back to Doctor's Care for review of the MRI and was noted to have bilateral tenderness to palpation with muscle spasm bilaterally in her trapezius distribution. She was prescribed a stronger pain medication and a steroid taper. (R. P. 358).

Claimant went for a claimant's IME with Dr. Timothy Zgleszewski. (R. p. 365). She reported to Dr. Zgleszewski that after the fall she had immediate pain in her mid-back, neck, and right wrist. (*Id.*). She further reported that she developed a stabbing sensation in her low back a few days later and reported continued problems with wrist pain, a scar with excess skin growth, and neck pain; despite the records from Doctor's Care that do not corroborate Claimant's statements to Dr. Zgleszewski. Dr. Zgleszewski stated that Claimant has probable facet joint dysfunction at all levels of her back and recommended a course of pain management-related treatment modalities. (R. p. 367).

Claimant's previous medical records from her family doctor were also submitted into evidence. Claimant presented to her family doctor on December 20, 2006 with complaints of right "neck pain" and noted that she had previously undergone massage therapy that was temporarily helpful, indicating that this was an ongoing problem for Claimant. (R. p. 271). Claimant was found to have tenderness in her neck and over the right trapezius muscles, (*Id.*), substantially similar to that which was noted in the Doctor's Care reports after March 24, 2011. These complaints recurred on April 7, 2008, when Claimant presented to her family doctor with complaints of neck and back pain with pain radiating to her right shoulder and pain with forward flexion. (R. p. 334). Claimant was noted to again have a palpable muscle spasm in her right trapezius and this was injected at the time. (*Id.*). Claimant's most recent documented recurrence of neck pain was on April 16, 2010. (R. p. 327). She presented to her family doctor on this occasion with complaints of right shoulder pain into the back of her neck that she described as constant and often a burning sensation. She again had a palpable right trapezius muscle spasm. (*Id.*).

Employer's personnel records regarding the circumstances of Claimant's workers' compensation claim and the false records that led to her termination were also included in the evidence of the case. (*See generally*, R. p. 373 – R. p. 618). Those records correspond with those discussed in the testimony of the witnesses.

ARGUMENTS

I. The Appellate Panel erred in finding that Claimant is entitled to temporary total disability benefits from March 21, 2011, to the present and continuing.

a. Claimant was not entitled to temporary total disability benefits as she had been released from any restrictions prior to her termination.

At the time of Claimant's termination, she had been released from any restrictions by her treating physician and had returned to full duty. As noted above, on March 18th, Claimant was seen at Doctor's Care for a follow-up appointment. The Return to Work form filled out following that visit and returned to Employer by Claimant indicated that could "perform full duty activities as of 3/18/11 without accommodations." (R. p. 349). Claimant returned to work on March 19 and 20; performing her full duties without restrictions. Claimant was then terminated on March 21, 2011. Consequently, it was error to find Claimant to be entitled to temporary total disability from Employer.

b. Claimant refused suitable employment in dereliction of S.C. Code Ann. § 42-9-190. Accordingly, the Appellate Panel's award of temporary total disability benefits was in error.

The substantial evidence in this case shows that Claimant was terminated for providing false information on her time correction form. Claimant's own testimony shows that she knew that she was supposed to clock out any time she left the facility for any reason. The undisputed evidence before the Appellate Panel shows that Claimant's time correction form did not reflect that she left the facility for her doctor's appointment on March 18, 2011. Ms. Burr testified that, pursuant to company policy, employees were not allowed to be paid for time missed from work in order to attend doctor appointments. Claimant's employee file shows that she was provided notice of this policy and that she signed this notice acknowledging that she had received and read the policy. Accordingly, the substantial evidence shows that Claimant was terminated for cause,

which constitutes an unjustified refusal of suitable employment. S.C. Code Ann. § 42-9-190 mandates that Claimant be barred from receiving temporary total disability benefits.

The Appellate Panel, in affirming and adopting the Decision and Order of the Single Commissioner, erroneously disregarded the explicit policy of Employer in finding that Claimant is entitled to temporary total disability benefits. The decision of the Appellate Panel is founded on its finding that it was implausible that "Claimant would intentionally put 9 years of service on the line for the one hour that she was at the doctor." The Appellate Panel further found that "it was obvious she was not trying to falsify records, deceive the Employer, or hide anything else." It was error on the part of the Appellate Panel to hold as it did based on these findings. Whether or not Claimant intended to mislead Employer for monetary gain is secondary to the fact that she stated that she knew that she was required to clock in and clock out any time she left the facility and was not to receive payment for time not at work. Claimant acknowledged as much when she testified that that workers are to clock out when going to retrieve something from their cars and return immediately. Despite her stated knowledge of company rules, Claimant nevertheless filled out and submitted a form wherein she represented to Employer that she had been at work from 7:30 a.m. to 10:30 a.m. when, in fact, she was not there for that entire time. Claimant's actions were in violation of company policy whether she intended to deceive or not. These actions constitute good cause for Claimant's termination.

Employer's time-clock policy is one of many designed to ensure that company records are accurate. This policy is a necessary requirement in order to deal with the heavy regulations of nursing facility administration. It is imperative for Employer to have a wholly accurate record of what personnel were onsite at any given moment of every day. Strict records must be kept to ascertain details such as resident-to-staff ratios and what personnel is available and providing care to residents at any given time. Proper staffing is imperative in this industry and, therefore,

there is a strong emphasis on attendance and record-keeping procedures. The Appellate Panel disregarded these obligations by focusing on whether or not Claimant *intended* to get paid or *otherwise deceive* Employer. Claimant's intentions are irrelevant as to her failure to properly and accurately complete her time correction form to show the time during which she was actually on site at the facility that led to her termination.

The findings of the Appellate Panel that Claimant would have clocked out, and that she was justified by not properly noting her time sheet, and thus granting her temporary total disability benefits are an undue burden on Employer in the management of its facility. Claimant was terminated based on a company policy that sites falsification of any records as grounds for immediate termination: a policy that the testimony shows has been enforced regularly in the past. The Commission's finding creates a situation where Employer has to treat workers' compensation claimants as an exception to the general rules to avoid being held responsible for temporary total disability benefits for terminating an employee based on its standard policy.

c. Claimant failed to prove that she is disabled.

Assuming *arguendo* that Claimant was under restrictions at the time of her termination, which is directly refuted by the evidence of record, Claimant, nevertheless, failed to prove that she is disabled within the meaning of the Act. "Disability" in the workers' comp context is defined as inability to earn the same wages as the injured employee earned pre-injury. S.C. Code Ann. § 42-1-120. As the evidence reflects, Claimant has achieved a level of education that makes it possible for her to earn a living without relying on her physical abilities. While there may have been certain physical aspects of Claimant's job as an RN in a nursing care facility, she certainly has a skill set that is transferrable to positions that do not involve taking care of invalids. Claimant expressed that she read advertisements for available positions in the newspapers and on the internet, but she never contacted the potential employers to see if she

could perform the jobs within her restrictions. There are work opportunities for nurses beyond that of resident care facilities and hospitals. Nurses are often employed in doctor's offices assisting in the care of able-bodied patients, as well as in various administration and clerical roles where their medical record keeping knowledge is needed. Claimant may have required specific accommodation to avoid working outside of her restrictions in a resident care facility, but in-patient caretaking is not the sole job opportunity for someone with Claimant's skills and she gave no indication that she had explored these alternative options or that she was incapable of performing other lighter duty positions in which nurses are employed. Simply put, Claimant did not set forth any evidence of "disability."

Based on the foregoing, the findings of the Appellate Panel that Claimant is entitled to temporary total disability benefits should be reversed.

II. The Appellate Panel made findings of fact that were internally inconsistent, contradictory and not supported by the substantial evidence in the record.

The Appellate Panel's decision was based on numerous findings of fact that were not supported by substantial evidence and, therefore, should be reversed.

a. The Hand Scanner

In its decision, the Appellate Panel found, in Finding of Fact No. 5, that "On March 11, 2011 and on numerous previous occasions the hand-scanning device did not work for the Claimant." In Finding of Fact No. 6, the Appellate Panel found that "on March 11, 2011 the Claimant was paid her normal hours although she did not clock out in order to go to Doctor's Care, *even though the hand-scanner was working that day.*" (emphasis added). The testimony of Claimant was that she clocked-in on the morning of March 11, 2011, but that she did not clock out that day because she was sent to Doctor's Care. There is no evidence in the record upon which the Appellate Panel could find that the device was not working on March 11, 2011.

Furthermore, the Appellate Panel found that Claimant “had always previously been paid when the scanner was broken and the claimant was required to clock in and out using the manual form.” There is insufficient evidence in the record establishing a period or pattern to support a finding that Claimant was “always” paid for missed time for medical visits. Moreover, this finding misses the point that the Employer’s policies required an employee to clock in and out for medical visits and the undisputed evidence shows that Claimant did not do this, whether through the hand-scanner or the manual form.

b. Work Restrictions

The Appellate Panel erroneously found that Claimant “continued to work even though working outside of her work restrictions” from March 11 to March 18. This finding is not supported by reliable, probative and substantial evidence.

Claimant’s testimony regarding her duties while under medical restrictions was extremely vague. She primarily described what her regular job duties were, and then asserted that she performed her normal job. Based on Claimant’s March 11, 2011 Return to Work Form (R. p. 343), Claimant restrictions included: no lifting more than 10 lbs., ground level work only, no repetitive bending, stooping, squatting, pushing, jerking, twisting, or bounding; no continuous standing for more than 30 minutes per hour; minimal walking or climbing; limited use of back; no overhead lifting; no high repetitive hand activities for extended periods of time; and no use of right arm. Claimant testified that she was required to “walk all around the facility in and out of resident’s rooms, doing a lot of paperwork, writing – I had to pull charts from overhead to get certain personal information to put on those forms. Sometimes I pushed the residents . . . I had to push them into their rooms in order to interview them.” Despite the fact that none of these described activities are outside of her work restrictions, Claimant responded “Yes” to being asked if she felt “that the new job that [her] employer had [her] performing violated those work

restrictions in some way?” Claimant offered no further testimony regarding how she “felt” her new duties were violating her work restrictions. Claimant’s restrictions from Doctor’s Care did not prevent her from walking or standing, only advised that she not walk or stand for more than 30 minutes per hour. This restriction was removed as of her follow-up visit on March 14, 2011. (R. p. 346). Claimant did not state with any specificity how far or how much she was required in walk to stand, other than “all around.” Moreover, this restriction was removed following Claimant’s March 14 doctor visit.

Similarly, Claimant’s testimony regarding pushing residents in wheelchairs does not support a finding of working outside of her restrictions. Again, the restriction on pushing only applied between March 11 to March 14 and Claimant did not testify as to any specifics as to length, duration or timing of these activities. Claimant also testified that while nurses had to engage in these activities, it was something nurses would do when CNAs were not available. Further testimony offered by Ms. Burr showed that employee’s with restrictions are charged with self-monitoring and they should ask for help or come to Ms. Burr regarding any task the employee should avoid.

Finally, Claimant’s assertion that she was working outside of her restrictions is undercut by the medical records indicating that Claimant asked to be released from restrictions so that she could perform her regular work. All available evidence, aside from Claimant’s self-serving and vague statements that her restrictions were not being met, indicates that Claimant’s job was indeed modified to meet her given work restrictions. The evidence also indicates that Claimant requested to be put back to full duty so that she could perform her regular work. Based on the forgoing, the finding of the Appellate Panel is unsupported by substantial evidence in the record and should be reversed.

c. Pay

The Appellate Panel found that “It was the Claimants [sic] clear understanding based upon the acts and information given by the Employer that led the Claimant to believe she was to be paid for time missed from work for her medical appointments.” This finding is unsupported by reliable, probative, and substantial evidence.

As Claimant testified, she was given and signed a written policy by Employer expressly stating that employees were not to be paid for time off from work due to doctor’s appointments. Claimant’s only evidence in contravention of this express written and acknowledged policy is Claimant’s testimony that it was her “understanding” that she had been paid her normal hours on March 11, 2011; the day she fell. This vague and unsubstantiated “understanding” does not support the Appellate Panel’s finding that “the acts and information given by the Employer” led to Claimant’s belief that she would be paid for time off work for doctor’s appointments. This is especially true given that Ms. Burr’s testimony that injured workers are made aware at the time of injury that they will not be compensated for missed time related to doctors’ visits.

d. Claimant’s Credibility

In its order, the Appellate Panel found Claimant to be a credible witness and, “but for the malfunctioning hand-scanner the Claimant would have clocked out, thereby not having to use the missed time form that the Employer used as an excuse for terminating her.” This finding is directly contradictory to the testimony of Claimant that she did not believe she had to clock out for her doctor’s appointment and that she was to be paid for that time. The Appellate Panel’s finding is based entirely on speculation and not supported by any reliable, probative and substantial evidence in the record.

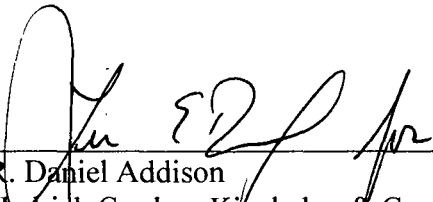
Similarly, the Appellate Panel found that “In the past when the hand scanner was working, the Claimant would clock into work, out for lunch, and back to work. If the hand-

scanner had been working on March 18, 2011 the Claimant would not have been terminated.” The Appellate Panel’s findings disregard the March 18th time form written by Claimant falsely asserting she was at work from 7 am. To 10:30 am. As noted above, such a finding is also contradictory to the other findings and Claimant’s testimony that she believed she would be paid for time off for doctor’s appointments. Moreover, Claimant’s practice in clocking in and out for lunch is not in any way probative of what Claimant did for doctor’s appointments, workers’ compensation procedures, or other instances closely related to the circumstances at issue in this case. The Appellate Panel’s finding is based entirely on speculation and not supported by any reliable, probative and substantial evidence in the record.

III. Conclusion

For all the above reasons, the Appellate Panel’s determination that Claimant should not be barred from receiving temporary total disability pursuant to S.C. Code Ann. § 42-9-190 is erroneous. Claimant did not satisfy her burden of proof by a preponderance of the evidence that she is entitled to temporary total disability benefits from March 24, 2011 to the present and continuing. The Appellate Panel’s conclusions are based on findings that are contradicted by the evidence in the record, internally inconsistent, and are not based on reliable, probative and substantial evidence. The reliable, probative, and substantial evidence in the record clearly shows that Claimant was provided with suitable modified duty to meet her restrictions, had been released to work without restrictions and was subsequently terminated for violation of company policy. Accordingly, Claimant’s petition for temporary total disability benefits from March 24, 2001 and ongoing should be denied.

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Andrea C. Roche, T. Scott Beck, Avery B. Wilkerson, Jr.
Workers' Compensation Commissioners

Tracking No. 2012-212326

WCC File No: 1103442

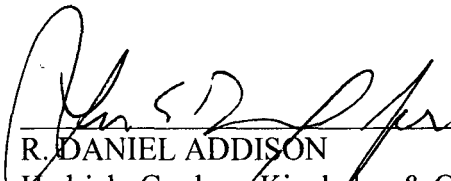
Gayla Ramey, Employee..... Appellant/Respondent

v.

Unihealth Post Acute Care Tanglewood, Employer, and
American Zurich Insurance Co., Carrier..... Respondents/Appellants

CERTIFICATE OF COMPLIANCE

The undersigned certified that Appellant's Final Brief complies with Rule 211(b).



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RECEIVED

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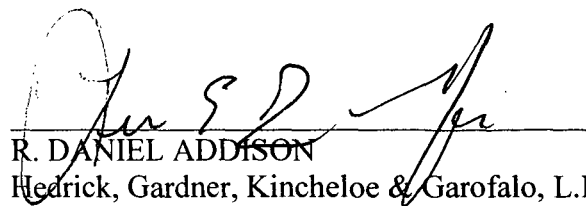
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PROOF OF SERVICE

This is to certify that a copy of the foregoing **Appellant's Final Brief** has been served upon the flowing by placing the same in the United States mail, first-class postage pre-paid, addressed as shown below on the 4th day of February, 2013.

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