

FILED

United States Court of Appeals
Tenth Circuit

UNITED STATES COURT OF APPEALS

FOR THE TENTH CIRCUIT

July 21, 2020

Christopher M. Wolpert
Clerk of Court

H. DENISE STUART,

Plaintiff - Appellant,

v.

ERICKSON LIVING MANAGEMENT;
WIND CREST,

Defendants - Appellees.

No. 19-1444

(D.C. No. 1:18-CV-01083-PAB-NYM)
(D. Colo.)

ORDER AND JUDGMENT*

Before **BRISCOE**, **MATHESON**, and **CARSON**, Circuit Judges.

H. Denise Stuart appeals from the district court's order granting summary judgment in favor of Defendants Erickson Living Management and Wind Crest on her claim of racial discrimination under Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-2(a)(1). Exercising jurisdiction under 28 U.S.C. § 1291, we affirm.

* After examining the briefs and appellate record, this panel has determined unanimously that oral argument would not materially assist in the determination of this appeal. See Fed. R. App. P. 34(a)(2); 10th Cir. R. 34.1(G). The case is therefore ordered submitted without oral argument. This order and judgment is not binding precedent, except under the doctrines of law of the case, res judicata, and collateral estoppel. It may be cited, however, for its persuasive value consistent with Fed. R. App. P. 32.1 and 10th Cir. R. 32.1.

BACKGROUND

In December 2016, Defendants hired Ms. Stuart as a Care Associate for patients suffering from dementia and Alzheimer's Disease at the Wind Crest facility in Highlands Ranch, Colorado. Her co-workers soon began complaining that she was bossy toward them, unreceptive to feedback, and rude toward residents and their family members. In March 2017, she received a written warning for failing to adhere to Defendants' values of respect, caring, teamwork, and excellence. When Ms. Stuart and a co-worker were involved in a verbal altercation two months later, Adam Dickson, Director of Continuing Care, decided to conduct a performance review "by interviewing both her co-workers and the family members of those residents for whom she cared." R. Vol. 1 at 212 (internal quotation marks omitted).

During his evaluation, Mr. Dickson received complaints from a resident's family members regarding Ms. Stuart's demeanor and care for residents, as well as complaints from co-workers that she ate food designated for residents and used inappropriate physical force on a resident. Mr. Dickson suspended Ms. Stuart while continuing to investigate. After receiving additional complaints that she refused to assist co-workers in times of need and was disrespectful to residents and co-workers, Mr. Dickson concluded Ms. Stuart's conduct violated Defendants' policies and standards of conduct and terminated her in June 2017.

Believing Defendants discriminated against her because she is Black, Ms. Stuart filed a discrimination charge with the Equal Employment Opportunity Commission, which dismissed the charge and issued a right-to-sue letter. She then

filed this action pro se, claiming racial discrimination and retaliation in violation of Title VII. Defendants moved to dismiss the retaliation claim, and a magistrate judge recommended granting the motion. Ms. Stuart did not file objections, and the district court accepted the recommendation.¹ Defendants then moved for summary judgment on the discrimination claim. Ms. Stuart did not file a response but, instead, filed her own summary-judgment motion. The magistrate judge recommended granting Defendants' motion and denying Ms. Stuart's motion. The district court accepted the recommendation over Ms. Stuart's objections. Ms. Stuart timely appealed.²

DISCUSSION

“We review the district court’s summary-judgment order de novo, applying the same standard that the district court is to apply.” *Doe v. Univ. of Denver*, 952 F.3d 1182, 1189 (10th Cir. 2020) (internal quotation marks omitted). A “court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” Fed. R. Civ. P. 56(a). “[W]e examine the record and all reasonable inferences that might be drawn from it in the light most favorable to the nonmoving party.” *Fields v. City of Tulsa*, 753 F.3d 1000, 1009 (10th Cir. 2014) (internal quotation marks omitted). A party opposing summary judgment, however, may not rely on “[u]nsubstantiated

¹ Although the court allowed Ms. Stuart twenty-one days to amend her complaint and properly plead the retaliation claim, she did not amend her complaint or otherwise attempt to resurrect this claim.

² We confine our review to the discrimination claim, as Ms. Stuart designated only the summary-judgment order in her notice of appeal.

allegations” or “mere speculation, conjecture, or surmise.” *Self v. Crum*, 439 F.3d 1227, 1230 (10th Cir. 2006) (internal quotation marks omitted).

Ms. Stuart is pro se, and therefore, “we liberally construe [her] filings.” *James v. Wadas*, 724 F.3d 1312, 1315 (10th Cir. 2013). But “we will not act as [her] advocate.” *Id.* “Our rules of appeal require appellants to sufficiently raise all issues and arguments on which they desire appellate review in their opening brief.” *Clark v. Colbert*, 895 F.3d 1258, 1265 (10th Cir. 2018) (brackets and internal quotation marks omitted). “[P]ro se parties [must] follow the same rules of procedure,” including filing a brief containing “more than a generalized assertion of error, with citations to supporting authority.” *Garrett v. Selby Connor Maddux & Janer*, 425 F.3d 836, 840-41 (10th Cir. 2005) (internal quotation marks omitted). “When a pro se litigant fails to comply with that rule, we cannot fill the void by crafting arguments and performing the necessary legal research.” *Id.* at 841 (brackets and internal quotation marks omitted).

In her opening brief, Ms. Stuart makes the conclusory assertions, unsupported by citation to the record or legal authority, that she “was falsely accused of elder abuse,” assaulted by a co-worker, subjected to disparate treatment and harassment, “compelled to work in a[] hostile environment,” and wrongfully terminated. Aplt. Opening Br. at 2. She further states, without explanation, that the district court “failed to notice important facts” and that the “judgement was unfair, unethical, and unconcern (sic).” *Id.* at 4. She also references three exhibits attached to her brief, which consist of two emails she sent to her supervisors regarding incidents with

co-workers as well a witness statement regarding the verbal altercation that prompted the investigation into her conduct and job performance. We “will not consider such issues adverted to in a perfunctory manner, unaccompanied by some effort at developed argumentation.” *United States v. Wooten*, 377 F.3d 1134, 1145 (10th Cir. 2004) (internal quotation marks omitted).

In her reply brief, which largely mirrors her summary judgment motion, Ms. Stuart contends that the proffered reason for her termination—poor performance—was false, that Defendants failed to properly investigate the accusations against her, and that five non-Black employees were not disciplined for violating Defendants’ policies. By failing to make these arguments in her opening brief and raising them only in her reply brief, Ms. Stuart has waived these arguments. *See Anderson v. U.S. Dep’t of Labor*, 422 F.3d 1155, 1174 (10th Cir. 2005).

In any event, the district court thoroughly addressed these claims as part of its analysis under the burden-shifting framework of *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 802-05 (1973). *See generally Crowe v. ADT Sec. Servs., Inc.*, 649 F.3d 1189, 1195 (10th Cir. 2011) (noting that “the plaintiff must first establish a *prima facie* case of discrimination,” that the burden shifts to the employer to show a “a legitimate, non-discriminatory” reason for the adverse action, and that the burden shifts back to “the plaintiff [to] show that the defendant’s proffered rationale is pretextual”). After assuming Ms. Stuart established a *prima facie* case of discrimination, the court concluded she failed to show Defendants’ legitimate, non-discriminatory reason for her termination—a pattern of poor performance, as shown

by complaints from both co-workers and relatives of Wind Crest’s residents—was in any way pretextual. The court specifically found she offered no competent evidence to rebut the evidence of poor performance or to support her allegation of an inadequate investigation. Moreover, the court found that the conduct of five non-Black employees she referenced was not sufficiently similar in severity or frequency to show disparate treatment. Finally, the court found “Defendants did discipline and/or terminate employees of varied race (e.g., Caucasian or Hispanic) for conduct like Ms. Stuart’s.” R. Vol. 1 at 222.

Ms. Stuart has not contested the district court’s findings or analysis, and “we will not question the reasoning of a district court unless an appellant actually argues against it,” *Clark*, 895 F.3d at 1265 (brackets and internal quotation marks omitted). Accordingly, she has failed to show the court erred in granting Defendants’ motion for summary judgment and denying her cross-motion for summary judgment.

CONCLUSION

The district court’s judgment is affirmed. We deny Ms. Stuart’s motion for leave to proceed in forma pauperis due to the lack “of a reasoned, nonfrivolous argument on the law and facts.” *Rolland v. Primesource Staffing, L.L.C.*, 497 F.3d 1077, 1079 (10th Cir. 2007).

Entered for the Court

Mary Beck Briscoe
Circuit Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO
Chief Judge Philip A. Brimmer

Civil Action No. 18-cv-01083-PAB-NYW

H. DENISE STUART,

Plaintiff,

v.

ERICKSON LIVING MANAGEMENT and
WIND CREST,

Defendants.

ORDER DENYING LEAVE TO PROCEED IN FORMA PAUPERIS ON APPEAL

Plaintiff H. Denise Stuart has filed a Notice of Appeal [Docket No. 80] and a Motion and Affidavit for Leave to Proceed on Appeal Pursuant to 28 U.S.C. § 1915 and Fed. R. App. P. 24 [Docket No. 81]. The Court has examined the file and has determined that leave to proceed *in forma pauperis* on appeal must be denied.

Pursuant to 28 U.S.C. § 1915(a)(3) and Rule 24(a)(3)(A) of the Federal Rules of Appellate Procedure, and for the reasons set forth in the Order [Docket No. 76], the Court finds that this appeal is not taken in good faith because plaintiff has not shown the existence of a reasoned, nonfrivolous argument on the law and facts in support of the issues raised on appeal.

Accordingly, it is

ORDERED that the Motion and Affidavit for Leave to Proceed on Appeal Pursuant to 28 U.S.C. § 1915 and Fed. R. App. P. 24 [Docket No. 81] is **DENIED**.



Occurrence type: Brain Injury

Occurrence ID: 1723A843004

Occurrence date: 03/01/2017

Occurrence Time: 23:05

Occurrence first known date: 03/02/2017

Reported by: Adam Dickson

Reporter phone: 303-876-8347

Report first received date: 03/02/2017 15:47

The following elements required for this to be a reportable occurrence of Brain Injury were met:

Result of occurrence(event)

Change in level of consciousness and/or loss of bodily function OR Diagnostic test which shows brain injury

Initial Occurrence Report:

On 3/1/2017 @ 11:05pm, resident #382815 had an un-witnessed fall in a common area sunroom on the memory care neighborhood. Resident is not oriented to person, place or time.

Resident was found by 2 caregivers during walking rounds. Resident found conscious on the floor; EMT's and on call nursing called immediately. Resident immediately sent to LAH via ambulance. Wife of resident also called by staff to alert of the fall and hospital transfer.

Hospital report received on 3/2/17 show a type 3 fracture of the dens with 10mm displacement resulting in moderate canal stenosis without frank cord suppression. Also a tiny subarachnoid hemorrhage was found.

Hospital reports no change in mental status post fall. Being treated in ICU tonight, continue with Keppra, follow up CT of head in AM, Neurosurgeon to see tomorrow regarding dens fracture. Resident is able to move all extremities to noxious stimuli.

We will monitor this case and follow up accordingly.

Client Information

(1) Client ID: #382815

ERICKSON000155

(2) Gender: Male

(3) Age: 81

(4) Physical/cognitive status of client before the occurrence: Resident had dx of: UNSPECIFIED DEMENTIA WITH BEHAVIORAL DISTURBANCE. He is not alert to person, place, or time. Resident ambulates independently. Resident requires stand by to hands on assistance for toileting, bathing, grooming and dressing.

Description of Occurrence

(1) What occurred? Describe the alleged event: On 3/1/2017 @ 11:05pm, resident #382815 had an un-witnessed fall in a common area sunroom on the memory care neighborhood. Resident was found by two caregivers (CNAs) during walking rounds. Resident found conscious on the floor; EMT's and on-call RN called immediately. Resident immediately sent to Littleton Adventist Hospital via ambulance.

(2) Describe the injury: Resident found to have one (1) inch laceration to forehead, small skin tear on right elbow, and two small abrasions on right hand. CT scan at hospital revealed small hemorrhage in left parietal region- SAH or cortical.

Resident also diagnosed with Type 3 dens fracture w/ 10mm displacement and moderate canal stenosis. There were also fractures of the bilateral lateral aspects of the posterior arch of C1 which was not displaced.

(3) Describe the functional loss: Fall resulting in fracture and brain injury and subsequent death at hospital two days later.

(4) Is the loss permanent or temporary? Explain: Permanent. Resident passed away in hospital.

(5) Was the occurrence witnessed? If yes, by whom? NO

(6) Who reported the occurrence? Caregivers (CNAs) working in the Memory Care Neighborhood contacted RN Manager on-call, resident POA, and EMTs.

(7) If reported by a staff member was it reported timely? YES, reported timely by staff

Facility Action

(1) Was the client assessed? If yes, by whom and when? YES

EMTs assessed resident upon arrival to building (called by CNAs).

(2) Was treatment provided to the client? If yes, describe the treatment, who provided it, and when it was provided? YES

EMTs completed assessment of resident. EMTs noticed resident grimacing during palpation of C-spine. EMTs and CNAs safely rolled resident into supine position. EMTs then placed resident in a side-lying position and

awaited Littleton Fire for hospital transfer.

(3) Was the client transported to the hospital? If yes, describe treatment, who provided it and when it was provided: YES

Resident underwent imaging of cervical spine upon arrival to hospital. Resident also started on Morphine and Keppra in emergency room. Resident was then transferred to ICU once stabilized.

Resident placed in 20 lb traction to stabilize C1-2 fractures. Resident began to desaturate due to increased secretions after midnight on 3/3. Bipap and suction utilized briefly before end of life care commenced. Resident passed away approximately 9 am on 3/3.

(4) What is the client's current status? Resident passed away in the hospital (respiratory failure).

(5) If this was a fall, was there a history of falls? YES

(5a) If yes, had the client been assessed concerning the falls? YES

(5b) Was a care plan in place to address the falls? If yes, please describe the care plan: YES

Resident has had only one(1) fall (occurred 12/2016). Fall occurred outside while resident was walking with private duty aide. Resident tripped on snow bank. Wind Crest team and family have been more mindful of outdoor walks since to ensure conditions are safe. Current care plan calls for frequent safety checks, re-assurance, and re-direction throughout the day, evening, and night. Team provides assistance with toileting, bathing, grooming and dressing.

(5c) If a care plan was in place, was it being followed? If no, please explain: YES

(6) If this was a choking incident was there a history of swallowing problems? Not a choking incident

(7) Were facility policies and procedures followed? If no, please explain: YES

(8) What interventions were put into place to prevent a recurrence? Please describe: Resident not returning to community, however, Wind Crest team was prepared to increase frequency of safety checks, and prepare other activity options, sports-specific, to support resident engagement (especially in the evenings).

Notifications

(1) Who was notified? Please check all that apply:

Physician
Family/Guardian

Back

Next

Exhibit 1

FW: Inappropriate/Unprofessional Incident at Work

From: Hazel Stuart <Hazel.Stuart@erickson.com>

To: d_stuart59 <d_stuart59@aol.com>

Date: ~~Redacted~~

April 28th 2017

From: Hazel Stuart

Sent: Saturday, April 29, 2017 5:55 AM

To: Nicole Gates

Cc: Dona Rubbo; Hazel Stuart

Subject: Inappropriate/Unprofessional Incident at Work / *Assault*

At the start of evening shift, I informed Justin I was taking the residents down for Happy hour. I stated that I needed him to support me in the dinner preparation or vice versa. After writing the resident's name on paper that chose to attend, I went over to the West side to see who was joining us. Justin and I were standing in the dining area closest to the bar waiting for the residents when Justin asked me if I was the Floater for today, I responded "no". Justin said to me "I thought we had already discussed and agreed whoever is assigned to Group 1 on Friday will escort the residents to Happy hour". Jill was also in the dining area assisting a resident as she was heading toward the hallway, she shoved my arm with her hand and pushed me to the side. I was shocked to what was happening, because we were not blocking entrance to the hallway. As a quick reflex I reached and moved her hand from my arm and stated to her "don't put your hand on me". She proceeded to walk off and responded in a sarcastic tone "please move". Two other Co-workers were sitting at a different table in the dining area, folding napkins during this time.

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Hazel Stuart

To: Sara Stover
Cc: Renae Staley
Subject: CNA Unprofessional Tone

Around 8pm, I went in to give Mary T. her meds, I informed the Son-In-Law of my return to put the cream under her breasts. When I returned to apply the cream, he stated "Kacey already put the cream on her" and he didn't know what kind of cream. I left the room to ask Kacey (CNA) what kind of cream she put on the resident. She stated in a loud tone, it was an ointment. As I informed her of the doctor's order for the cream, she stated loudly, "you QMAPS need to let the CNA's know when a resident has A rash and use special cream". As I tried to inform her that the nurse will be the one to inform her of a doctor's order, she continue speaking in a loud tone, so I stop talking. We both went into the resident's room, she washed the ointment off (Aloe Vesta Protective Ointment), and then she apologized to the Son-In-Law. For putting the wrong cream on. Afterward, I came in the office and contacted the On-call nurse; I left a voice message to contact me. As I was sitting in the office waiting for the callback, I opened the Communication Binder to document and read her note. She falsely stated, she was yelled at, when she was the one doing the yelling. Renee returned the call back and I informed her of this, along with send her and Sara an email concerning this.

H. Denise Stuart

Exhibit 15



Add more Living to your Life™

Witness Statement

Date of Accident: 5-23-17

Riskonnect Event # 9500

Name: Daniiesha White

Time of Accident 8:30 AM / PM

Accident Location: West Side

Phone: 720-774-9600

State, in your own words, how the accident occurred:

I was sitting on the west side and heard Kaycee yelling at Denise Stuart as they were walking into a residents room. Then Denise was silent with her head down walking as Kaycee was yelling at her.

I affirm the information supplied in this statement is truthful and accurate to the best of my ability.

Daniiesha White

Signature

5-23-17

Date

10:11 AM / PM

Time

ERICKSON000062