Issue: Group III Written Notice with Termination (sleeping during work hours and client neglect); Hearing Date: 04/23/18; Decision Issued: 05/05/18; Agency: DBHDS; AHO: Carl Wilson Schmidt, Esq.; Case No. 11188; Outcome: No Relief – Agency Upheld.

COMMONWEALTH OF VIRGINIA

OFFICE OF EQUAL EMPLOYMENT DISPUTE RESOLUTION
DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In the matter of: Grievance Case No. 11188

Hearing Date: April 23, 2018
Decision Issued: May 5, 2018

PROCEDURAL HISTORY

On January 19, 2018 Grievant was issued a Group III Written Notice with termination of employment effective 1/19/18.[1] Grievant filed a Grievance Form A challenging Agency's issuance of the Group III Written Notice with termination and the matter was subsequently qualified for hearing. The undersigned was appointed Hearing Officer effective March 26, 2018.

On 4/17/18 Grievant and Agency Advocate indicated to Hearing Officer each had additional documents desired to be admitted into evidence which had not exchanged by the 4/16/17 exchange due date. A conference call was held 4/17/18 to discuss these documents. At the conference call Grievant and Agency Advocate indicated no objection to admission of such documents. By agreement of the parties, such documents were admitted into evidence at the 4/23/18 hearing held in this cause at Facility.

APPEARANCES and EXHIBITS

A. The following appeared at hearing:
   Agency's Advocate at Hearing
   Agency party designee at hearing
   Grievant (who was also a witness)
   Witnesses

B. Exhibits were admitted, by agreement of the parties, *en masse* and consists of:

   Agency's exhibits page numbered 1-166 (with certain pages also having subordinate pages bearing the same page number with alphabetical

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[1] G. pg. 38.

designations). Agency exhibits are referenced herein as "A. pg. __" with the page number inserted at the "__".

Grievant's exhibits are page numbered 1-10 with the two fax transmittal pages of such exhibits also included. Grievant's exhibits are referenced herein as "G. pg. __" with the page number inserted at the "__".

Two additional exhibits were admitted, by agreement, at hearing and labeled *Hearing Exhibit A* and *Hearing Exhibit B*.

ISSUES

Whether the issuance of a Group III Written Notice with termination was warranted and appropriate under the circumstances?

BURDEN OF PROOF

The burden of proof is on the Agency to show by a preponderance of the evidence that its disciplinary action against Grievant was warranted and appropriate under the circumstances. A preponderance of the evidence is evidence which shows that what is intended to be proved is more likely than not; evidence that is more convincing than the opposing evidence.[2]

The employee has the burden of raising and establishing any affirmative defenses to discipline and any evidence of mitigating circumstances related to discipline. [3]

FINDINGS OF FACT

After reviewing all the evidence admitted and observing the demeanor of each witness, the Hearing Officer makes the following findings of fact:

01. Grievant was issued Group III Written Notice on 1/19/18 for *sleeping during work hours* and *patient neglect*. Under Nature of Offense and Evidence the Written Notice provided:

> Violation of Departmental Instruction 201, Reporting and Investigating Abuse and Neglect of Clients as defined in Section 201-3, and [Facility] Instruction #106 and Department of Human Resource Management Policy No. 106 -"Standards of Conduct" and [Facility] Policy 10. The results of the investigation did substantiate neglect to the client based upon physical, documentary, and testimonial evidence. Due to the nature of the offenses [Grievant] will receive a Group III Written Notice and termination as

[2] Dept. of Employment Dispute Resolution, *Grievance Procedure Manual*, Sections 5.8 and 9.
[3] Office of Employment Dispute Resolution, DHRM, *Grievance Procedure Manual*, Sections 5.8 and 9.

instructed in Departmental Instruction 201 when referring to a substantiated finding of abuse/neglect. [4]

02. Grievant was employed as a Direct Support Professional/Direct Service Associate II at Facility and has been employed by Agency for approximately 3 years and 9 months.[5] As such she works directly with intellectually disabled individuals, supplying them with their basic needs including medical, personal hygiene, training needs. Grievant is also responsible for implementing program plans assuring active treatment is provided, ensuring a safe environment is provided, and completing required documentation.[6]

03. The 3rd shift on 12/5/17 at Facility began on or about 11:00 p.m. and continuing until on or about 7:00 a.m. on 12/6/17. On this shift Grievant was the only direct service provider assigned to the unit housing Client until on or about 6:15 a.m. on 12/6/17 when another direct service provider came in. As such, Grievant was responsible for providing services to Client on the 3rd shift.[7]

04. Client is an adult male receiving services at a Facility, which is operated by the Department for the treatment persons with a mental illness, developmental disability, or substance abuse and responsible for providing services to such persons. Client has resided at Facility for approximately 12 years.[8]

05. Client is intellectually disabled, blind, and has been diagnosed with Stereotypic Movement Disorder with Self-injurious Behavior and Autism Spectrum Disorder. He engages in self-injurious behaviors including hitting himself, biting himself, banging his head, kicking himself, and kicking objects. Client is unable to adequately communicate his wants or needs but uses gestures, vocal noise, facial expression, body language, and signs to indicate his likes and dislikes. He exhibits agitation and disruption by loud vocalizations, throwing objects, flopping to the floor, stamping feet, pushing others or materials away, pulling staff, and resisting assistance from staff.

Client wears a helmet with face shield, which he prefers to wear most times as a self-security device, and is the sole occupant of a bedroom at Facility. Interventions are required to help minimize self-inflicted injuries and promote more effective responses to stressors.[9]

06. Client has a Behavior Support Plan and a Physical Management Plan in effect at Facility.[10] The Behavior Support Plan at Facility, dated 06/05/17, addresses his current conditions,

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[4] A. pg. 38.
[5] A. pg. 41 and testimony.

[6] A. pg. 41.

[7] Testimony.

[8] A. pg. 12.

[9] A. pg. 12-33 and testimony.

diagnoses, behaviors, and history. Among other matters, per Administrative Directive, the Behavior Support Plan requires a Room Audio Monitor be in operation in Client's room and requires staff to have the receiving monitor on them when out of hearing distance of Client so staff can hear sounds he produces and provide assistance to Client. The plan also requires Client's room to have a door monitor to alert staff when he leaves his bedroom.[11]

07. At approximately 7:00 am on 12/6/17 Grievant went to Client's bedroom to get him up for the morning. Client's helmet was on the floor and his head wrapped up in his top sheet. Client had a large abrasion on his forehead and the knuckles on his left hand were skinned. This was the first time Grievant observed such injuries.[12]

08. Agency initiated an investigation on 12/6/17 into matters related to Client's abrasions and skinned knuckles. During such investigation, Investigator interviewed employees, including Grievant, took photographs of Client's injuries, and conducted a review of documents. Investigator filed his written "Investigator's Summary" December 15, 2017 in which he concluded, "The results of the investigation did substantiate neglect to [Client] ... ".[13]

09. On 3/10/14 Grievant signed an *Electronic Acknowledgment of Materials* acknowledging she received a copy, read, and understood documents, policy, Departmental Instructions, and other matters, including:

Policy #10 ... Resident Abuse
Policy # 106 ... Standards of Conduct
DI 201 (RTS)03 ... Reporting and Investigating Abuse and Neglect of Clients
DMHMRSAS Employee Handbook[14]

Additionally, Grievant, signed documents indicating she had read or had explained to her the contents of the following:

On 06/05/16 ... Facility Instruction #010 - Resident Abuse, date revised: 05/12/15.[15]
On 12/11/14 ... Facility Instruction #414 - General Care Guidelines, date revised 12/09/14.[16]

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[10] Testimony, A. pg. 57-62 and A. pg. 63-64.

[11] A. pg 57-62.

[12] A. pg. 14 and testimony.

[13] A. pg. 12-33 and testimony.

[14] A. pg. 48.

[15] A. pg. 158.

[16] A. pg. 159.

On 11/27/14 ... Facility Instruction #414 - General Care Guidelines, date revised: 11/18/14.[17]

CONCLUSIONS:

The General Assembly enacted the Virginia Personnel Act, Va. Code § 2.2-2900 et seq., establishing the procedures and policies applicable to employment within the Commonwealth of Virginia. This comprehensive legislation includes procedures for hiring, promoting, compensating, discharging, and training state employees. It also provides for a grievance procedure. Code of Virginia, §2.2-3000 (A) sets forth the Virginia grievance procedure and provides, in part:

> "It shall be the policy of the Commonwealth, as an employer, to encourage the resolution of employee problems and complaints .... To the extent that such concerns cannot be resolved informally, the grievance procedure shall afford an immediate and fair method for the resolution of employee disputes which may arise between state agencies and those employees who have access to the procedure under §2.2-3001."

To establish procedures on Standards of Conduct and Performance for employees pursuant to §2.2-1201 of the Code of Virginia, the Department of Human Resource Management ("DHRM") promulgated the *Standards of Conduct, Policy No. 1.60*, *effective April 16, 2008.*[18] DHRM Policy 1.60 - *Standards of Conduct* organizes offenses into three groups according to the severity of the behavior. Group I Offenses include acts of minor misconduct that require formal disciplinary action. Group II Offenses include acts of misconduct of a more serious and/or repeat nature that require formal disciplinary action. Group III Offenses include acts of misconduct of such a severe nature that a first occurrence normally would warrant termination. Attachment A to the *Standards of Conduct* provides abuse or neglect of clients is an example of a Group III Offense and also provides sleeping during work hours is an example of a Group III Offense.[19]

[Facility] Instruction 106, *Standards of Conduct,* ("I-106") was published and promulgated to establish procedures for implementing corrective actions in accordance with the provisions of the State Standards of Conduct when unsatisfactory behavior or performance has occurred. § 5.(A.)(3.)(a.) of I-106 provides, "Employees are expected to abide by all policies promulgated by the Department of Human Resource Management, the Department of Behavioral Health and Developmental Services, and the facility."

I-106 provides Group III Offenses include acts of misconduct of such a severe nature that a first occurrence normally should warrant termination.[20] Attachment A to I-106 provides that "abuse or

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[17] A. pg. 160.
[18] A. pg. 67-89.

[19] A. pg. 89.

[20] A. pg. 105.

neglect of clients" is an example of a Group III Offense and also provides that "sleeping during work hours" is an example of a Group III Offense.[21]

I-106 § 5.(C.)(3.) provides examples of offenses, by group, are presented in Attachment A. Additionally I-106 provides these examples are not all-inclusive, but are intended as examples of conduct for which specific disciplinary actions may be warranted. Accordingly, any offense not specifically enumerated, that in the judgment of agency heads or their designees undermines the effectiveness of agencies' activities, may be considered unacceptable and treated in a manner consistent with he provisions of this sections.[22]

Instruction 414:

[Facility] Instruction 414 *General Care Guidelines* ("I-414") stated purpose is, "To assure the safety and individual rights of individuals at all times and provide the highest level of care possible". I-414 addresses staff requirements for conducting bed checks and provides:

> Observations: Staff working with individuals must be aware of the location of each individual at all times. Headcounts are to be done every 15 minutes, 24 hours a day. When individuals are in bed, nighttime or daytime, bed checks must be done at least every 30 minutes, or per Physician's orders or PS Team recommendations. The staff person doing bed checks will enter each room and closely observe the individual. It is not sufficient to look in from the doorway. If the individual is asleep, the staff person should assure that he/she is breathing properly and resting comfortably. ...
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> It is understood that interruptions, such as to care for personal hygiene needs, could prevent immediate documentation. However, documentation on the bed check chart is to normally be done every 30 minutes, but no later than 1 hour after the bed check has been completed.[23]

DI-201 and I-10[24]

Departmental Instruction 201 ("DI-201") sets out Agency's policy of no tolerance for abuse and neglect. DI-201 applies to Agency's entire workforce and provides each individual receiving services in a state facility has the right to be protected from harm including abuse.

DI-201 defines "Abuse" providing, "This means any act or failure to act by an employee or other person responsible for the care of an individual in a facility operated by the department that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or

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[21] A. pg. 112.

[22] A. pg 105.

[23] A. pg. 138-139.

[24] A. pg. 145-156 and A. pg. 90-100.

might have caused physical or psychological harm, injury, or death to an individual receiving care or treatment for mental illness, developmental disability, or substance abuse. ... "[25]

DI-201 defines "Neglect" providing, "This means the failure by a program, or facility operated by the department, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for a mental illness, developmental disability, or substance abuse."[26]

Pursuant to [Facility] Instruction 10 ("I-10) it is the policy of [Facility] that abuse or neglect of residents shall not be condoned or tolerated. It is expected that a facility director will terminate an employee found to have abuse or neglected a client. However, it also provides for a procedure permitting a lesser disciplinary action if a facility director determines, based on established mitigating factors, disciplinary action may warrant a lesser penalty than termination.

I-10 also defines "Neglect" stating,

> "Neglect" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Correction, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment for mental illness, mental retardation, or substance abuse."[27]

Client:

Client is a blind, Autistic, ID, adult male with Stereotypic Movement Disorder who engages in self-injurious behaviors including banging his head, hitting himself, and biting himself. He is also unable to adequately communicate his wants or needs but cues uses gestures, vocal noise, facial expression, body language, and signs to indicate likes and dislikes.

In addition to self-injurious behaviors there was a prior incident at Facility in which Client was found in another resident's room, standing over the resident who was in bed, and the resident having sustained scratch marks and bruising from being pinched.

Client continues to exhibit behaviors which pose the potential for self-inflicted injury and interventions are required to help minimize self-inflicted injuries and to promote more effective responses to stressors.[28]

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[25] A. pg. 145.

[26] A. pg. 146.

[27] A. pg. 90-100.

[28] A. pg. 58.

Client has a Behavior Support Plan (6/5/17). The Plan Focus is decreasing the frequency and intensity levels of self-injurious behaviors and the potential for injury secondary to same. His Behavior Support Plan address responses to self-injurious behaviors and requires, if his behavior continues to escalate with no indication of calming, that staff is to call and ask a Code Red be called.[29] The Behavior Support Plan is in effect 24 hours a day.[30]

As a part of Client's Behavior Support Plan, per administrative directive, a room monitor is require to be in operation in his bedroom to allow staff to hear sounds he produces and provide interventions as needed. The Plan requires staff to have the receiving monitor on them when out of hearing distance of Client.[31]

Grievant is familiar with Client and aware Client had a Behavior Support Plan. She has received training concerning Client's Behavior Support Plan and Data Collection training.[32]

Incident:

Grievant volunteered to work 3rd shift, beginning on or about 11:00 p.m. on 12/5/17 and ending on or about 7:00 a.m. on 12/6/17. Grievant was the only direct service provider assigned to the unit Client resided in until on or about 6;15 a.m. on 12/6/17 when another direct service provider came in. On this 3rd shift Grievant had 6 residents, including Client, she was responsible for.

As a part of her duties she was required to do bed checks on Client and the five other residents at least every 30 minutes while they were in bed. Additionally, she was charged by policy, with timely documenting matters. Grievant was also required to have the receiver to the electronic audio monitor located in Client's room and to monitor any noises from his room.[33]

At about 7:00 a.m. Grievant went to Client's room to wake him up and discovered Client's helmet was on the floor, his head was wrapped up in his top sheet, he had a large abrasion on his forehead, and the knuckles on his left hand were skinned. While the evidence indicates Client had a large abrasion on his forehead and the knuckles on his left hand were skinned, there is no evidence presented in this cause to find these were other than self-inflicted injuries.

Investigation and concerns:

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[29] A. pg. 57-61.

[30] Testimony.

[31] A. pg. 57-62.

[32] A. pg. 55-56.

[33] Testimony.

Investigator was contacted and on 12/6/17 an Agency investigation was initiated into the circumstances surrounding Client's injuries which were first discovered by Grievant at about 7:00 a.m. on 12/6/17.

Nurse Practitioner examined Client at about 10:00 a.m. on 12/6/17 and described his injuries as being multiple self-inflicted contusions and abrasions. Upon her reviewing interdisciplinary notes of Grievant and observing Client's injuries Nurse Practitioner felt the injuries occurred sometime between 12/5/17 at 10:00 p.m. (when Grievant did a body check of Client and found no injuries) and 7:00 a.m. on 12/6/17 (when Grievant first discovered the injuries).

Upon conclusion of his investigation, Investigator filed a written "Investigator's Summary" on December 15, 2017. In his "Investigator's Summary" Investigator concluded the results of his investigation did substantiate neglect to Client. Agency review of the *Investigators Summary* and matters addressed therein gave rise to concern as to Grievant's violations of policy, including neglect of Client and sleeping at work.

Agency was concerned Grievant, the direct service provider responsible for Client on the 3rd shift, slept during work hours, did not monitor Client's room audio monitor, did not conduct bed checks per policy, and did not document matters per policy. Concern was also expressed bed checks are especially important for Client, given his history of self-injury and entering into other resident's rooms. Client's Behavior Support Plan required an audio monitor to be in his room and for staff to have the receiving monitor on them when out of hearing distance of Client.

Grievant's written interdisciplinary note of 12/5/17 at 10:00 p.m. documented Client had a body check which was completed with no problems noted. Her written interdisciplinary note of 12/6/17 at 7:00 a.m. documented abrasions on Client's forehead and that the knuckles on his left hand were skinned. Grievant, when questioned, stated the injuries were not present when Client was last checked at 5:00 a.m.[34]

Nurse Practitioner examined Client injuries and concluded they occurred between 12/5/17 at 10:00 p.m and 7:00 a.m. on 12/6/17.[35] Nurse Practitioner further opined that the injury was self-injurious behavior probably in response to pain from an ear infection.[36]

Sleeping:

Grievant was observed by DSP to be sleeping at 4:00 a.m., at 4:20 a.m., and 5:30 a.m. on 12/6/17. DSP came into work at 4:00 a.m. on 12/6/17 and was working on another unit within the

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[34] A. pg. 18.

[35] Testimony.

[36] Testimony.

same building as Grievant. DSP observed Grievant asleep in the living room with the TV on. In her 12/6/17 written statement DSP stated:

> I came in at 4:00 A.M. to relieve [name] on [unit]. [Grievant] was in the living room with the TV on very loud. She was sound asleep. [Name] woke her up to say goodbye and that he was leaving. This was about 4:15 AM. I went to the restroom at about 4:20 AM. [Grievant] was in the recliner with it reclined back, and she was sound asleep. The TV was still very loud. I sat down beside her put my hand on her arm and called her name twice. She did not respond. I went back to the office on [unit] and began doing data.
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> At 5:30 AM I went back to the living room and woke [Grievant] up; told her what time it was and that we needed to start getting the guys up. She got up from the recliner, turned the TV down and went to the office on the [unit] side. I followed her and she said that she had to do paperwork. The monitor was in the office but there was no noise coming from it and [Client's] door was closed.[37]

In a 12/15/17 telephone call Grievant told Investigator she "may have dozed for moment here and there". Grievant further stated she would not wake up for DSP but wasn't sleeping. She said she would rather just not have to talk to DSP and, if DSP thought Grievant was sleeping, DSP will be quiet.[38] Subsequently, at hearing Grievant testified she was not trying to deny she was sleeping, she didn't know, and it wouldn't surprise her as she was exhausted.

The evidence indicates Grievant was, as Agency alleged, sleeping during work hours.

Bed checks:

I-414 requires bed checks be conducted at least every 30 minutes when residents are in bed. The staff person doing bed checks is required to enter each room and closely observe the individual to assure the person is breathing properly and resting comfortably. Furthermore, documentation on the bed check chart is to normally be done every 30 minutes, but no later than 1 hour after the bed check has been completed.[39]

Bed checks are considered an important part of 3rd shift duties. Employees are required to document required bed checks using a "BEDCHECK CHART" form for each resident. The form has lines for each day of the month and intersecting columns with printed times (in 30 minute increments) for information to be entered. [40]

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[37] A. pg 21.

[38] A. pg 16.

[39] A. pg.138 -139 and testimony.

[40] A. pg 25.

When Investigator asked to see Client's BEDCHECK CHART Grievant stated, "don't pay any attention to that". Investigator felt this suggested to him the bed check chart may not be accurate. On 12/6/17 Grievant gave a written statement that the BEDCHECK CHART is filled out once or twice a shift because, between changing residents and bedding, there was no time to return to the office to complete bed check paperwork.[41]

The evidence indicates Grievant first observed Grievant with the contusion to his forehead and skinned knuckles at 7:00 a.m. on 5/6/17 and she had last seen Client at about 5:00 a.m. Grievant's 12/6/17 signed statement provided, in pertinent part:

> I went into [Client's] bedroom at about 7:00 am to get him up this morning ...
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> The last time I saw [Client] when he was in bed with his helmet on was about 5:00 am when I checked him and continued on to check other residents on the unit and start getting them up. ...
>
> The bedcheck chart is filled out once or twice a shift ...

In her letter in response to Agency's proposed actions, Grievant stated, The last time she look at [Client] at 5:00 a.m. he was fine." She also stated, "We continued to get residents up until 7am when I went in [Client's] room." [42]

Upon consideration of the evidence in this cause, Agency has met its burden that Grievant did not conduct bed checks as required by policy and also did not timely document bed check information.

Neglect:

Grievant was assigned to work on Client's unit and responsible for providing care and services to Client and the unit's five other residents. She was responsible for, but failed providing services to Client which were necessary to his treatment, health, safety, and welfare.

Grievant was aware of Client's physical and mental condition including his self-injurious behaviors and aware of his Behavior Support Plan, including its requirements for a room monitor and door monitor. Grievant was also aware of the requirement to monitor the noises/sounds occurring in his room. Grievant was aware of policy requirements of bed checks being conducted at least every 30 minutes.

It is not contested Client sustained injuries and his injuries were first discovered at 7:00 a.m. on 12/6/17 by Grievant when she entered his room to get him up for the day. The evidence indicates she did not conduct bed checks at least every 30 minutes on Grievant. Grievant, as a minimum, did

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[41] A. pg 20.

[42] A. pg. 36.

not conduct a bed check of Client between 5:00 and 7:00 on the morning of 5/6/17 and, as a minimum, did not monitor the noises/sounds coming from Client's room while she was sleeping.

Grievant:

Grievant normally worked 2nd shift but requested to work overtime shifts and was scheduled on 12/4/17 and on 12/5/17 to work double shifts (ie. 2nd and 3rd shifts) each day. Shortly after reporting to her regular 2nd shift on 12/4/17, Grievant received a call her father was injured and he went to the hospital. Upon contacting a supervisor, she asked for and received permission to leave work to go the hospital. She returned to Facility at the beginning of her overtime 3rd shift beginning on 12/4/17.

After finishing 3rd shift Grievant went back to the hospital the morning of 12/5/17. She remembered dozing in the waiting room and then went home, fed the animals, and changed clothes. Grievant stated she remembered nothing on second shift which began on 12/5/17 and her memory comes and goes.

Grievant raises a number of matters including memory issues, health issues, and stress. She contends her stress and physical conditions caused increased fatigue, insomnia, and anxiety which contributed to and/or are responsible for what occurred.

A 4/1/18 document from Grievant's doctor was admitted concerning the office visit of 3/29/18. The document indicate, among other matters:

> Dx: Localization-related (focal) (partial) symptomatic, epilepsy and epileptic syndrome with complex partial seizures, not intracticable, without status epilepticus [G40.209] (Active), Other amnesia [R41.3] (Active), Sleep deprivation [Z72.802] Active, Personal history of nicotine dependence [Z87.891] (Active), Other long term (current) drug therapy [Z79.899] (Active)..

The document of 4/1/18 also stated, "She has been very well controlled on [medication] and [medication] chronically." The document also indicated Grievant was last seen by the physician on 12/20/16 and on 3/29/18 was given instructions to return in about 1 year (around 3/29/19).[43]

Agency does not allow employees to work more than 16 consecutive hours. Agency has provisions for allowing employees to leave work early, reduce hours, or not work a shift (regular or overtime) when various situations arise. Agency, on Grievant's request, allowed her to leave work on 12/4/17 at the beginning of 2nd shift. However, Grievant did not request permission to leave work early, reduce her hours, or be excused from working on either the 2nd or 3rd shifts of 12/5/17.

Management expressed concern Grievant, under the circumstances, did not request to be excused from work. Management opined, given her situation, if requested, her shifts or hours working could have been adjusted or she could have been excused from showing up for work. In the past

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[43] G. pg 6-8.

management has often permitted employees to adjust working hours or not show for a scheduled shift, whether regular or overtime shifts, when requested.[44] Grievant acknowledged she didn't know why she chose to work 3rd shift.

Grievant contends the telephone interview with Investigator on 12/17/17 took place while she was sleeping, she was talking in her sleep, and the statements did not apply to the investigated event.[45] The telephone conversation with Investigator occurred on 12/15/17. Irrespective of the date it occurred, Grievant stated to Investigator she "may have dozed for moment here and there". Grievant also testified at hearing she was not trying to deny she was sleeping, she didn't know, and it wouldn't surprise her as she was exhausted.

Grievant discussed a number of matters with Investigator and asked questions of Investigator in their telephone conference. She told Investigator she would not wake up for DSP but wasn't sleeping, as DPS gets on her nerves and she would rather just not have to talk to her. She noted if DPS thinks she was sleeping she will be quiet. Grievant also asked Investigator if she was the only one being investigated.[46]

Grievant stated in her 2/13/18 written statement "I remember walking out of my father's hospital room to leave for home. I have no memory of anything else until sometime during 3rd shift when I was changing [Client] with [other DSP].[47]

Grievant was sleeping during work hours. She chose to work the 3rd shift and not request management to be excused from working the shift. Grievant also appears to be raising matters relating to accommodations stating, "What ever happened to me on the night of 12/5/17 I believe was a result of excessive stress and should have been treated as a medical issue."

Pursuant to the Americans with Disabilities Act ("ADA") an individual is considered to have a disability if that individual either (1) has a physical or mental impairment which substantially limits one or more of his or her major life activities, (2) has a record of such an impairment, or (3) is regarded as having such an impairment. Furthermore, a qualified individual with a disability is defined as one who "satisfies the requisite skill, experience, education and other job-related requirements of the employment position such individual holds or desires, and who with or without reasonable accommodation, can perform the essential functions of such position."[48]

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[44] Testimony.

[45] A. pg. 3.

[46] A. pg. 23 and 16.

[47] A. pg 8.

[48] 29 CFR § 1630.2(m).

Under the ADA an employer cannot discriminate against an employee because of a disability and an employer has a duty as to the provision of reasonable accommodations. However, the ADA does not excuse an employee from meeting the same performance and conduct standards as other similarly situated employees without disabilities.

An employer is not required to provide an accommodation if unaware of the need.[49] Grievant has the responsibility to inform Agency if an accommodation is needed to perform essential job functions. However, Grievant has never requested an accommodation.

While the ADA does not require an employee to ask for an accommodation at a specific time, the timing of a request for reasonable accommodation is important as an employer does not have to rescind discipline when no request was made prior to discipline.[50]

The ADA generally affords employers the latitude to develop and enforce conduct rules for their employees. An employer may discipline an employee with a disability for violating a conduct standard if the disability does not cause the misconduct and may hold the employee to the same conduct standards it applies to all other employees. However, even if were found that Grievant had a disability which caused or contributed to the misconduct alleged, discipline may still be issued. An employer may discipline an employee with a disability for violating a conduct standard even if the disability causes or contributes to the misconduct if the conduct rule is job-related, the conduct rule is consistent with business necessity, and other employees are held to the same standard.[51]

Grievant was aware of the Agency policy prohibiting sleeping at work, was aware of Agency policy prohibiting the neglect of a person receiving care or treatment at Facility, and was aware of requirements to conduct bed checks at least every thirty minutes. Policy, applicable to all employees at Facility, prohibits employees from sleeping during work hours, prohibits the neglect of clients/residents at Facility, and requires bed checks at least every thirty minutes. Given the nature of the Facility and its clients/residents, the requirement for bed checks at least every thirty minutes and the prohibitions against sleeping at work and neglect of clients/residents, are job related and consistent with business necessity. Furthermore, other employees are held to the same standard.

The Hearing Officer finds, for the above reasons, the ADA does not act to bar or preclude the actions of the Agency.

Mitigation:

Va. Code § 2.2–3005.1 authorizes a hearing officer to order appropriate remedies including "mitigation or reduction of the agency disciplinary action." Mitigation must be "in accordance with the

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[49] EEOC Technical Assistance Manual § 3.6.

[50] Hill v. Kansas City Area Transp. Auth., 181 F.3d 819 (8th Cir. 1999).

[51] 29 C.F.R. §§ 1630.10(a), 1630.15(c).

rules established by the Department of Human Resources Management ...”.[52] The hearing officer must receive and consider evidence in mitigation or aggravation of any offense charged by an agency.[53]

The *Rules for Conducting Grievance Hearings* provide that a hearing officer is not a “super-personnel officer" and, therefore, in providing any remedy, the hearing officer should give the appropriate level of deference to actions by agency management that are found to be consistent with law and policy. Furthermore, a hearing officer may mitigate the agency’s discipline only if, under the record evidence, the agency's discipline exceeds the limits of reasonableness and, if the hearing officer mitigates the Agency's discipline, the hearing officer is charged with stating in the hearing decision the basis for mitigation.

Grievant has the burden to raise and establish mitigating circumstances that justify altering the disciplinary action consistent with the “exceeds the limits of reasonableness” standard. The Agency has the burden to demonstrate any aggravating circumstances that might negate any mitigating circumstances.[54]

Consideration is given to all the evidence presented in this cause, including Grievant’s approximate 3 years and 9 months employment and there being no evidence of any prior active discipline. Consideration is also given to the matters and circumstances she raised including, but not limited to matters related to stress, her memory issues, health issues, fatigue, insomnia, and anxiety.

Consideration is also given to the nature of Facility and its residents, as well as the responsibility of Agency and its staff to provide a safe environment for individuals in its care. Consideration is also given to policy, Client’s physical and mental condition including his, self-injurious behaviors, his injuring himself, and his Behavior Support Plan which included monitoring requirements.

Upon consideration of the above the hearing officer does not find, under the record evidence, the agency’s discipline exceeds the limits of reasonableness.

DECISION

Agency has met its burden of proof, by a preponderance, that Grievant was sleeping during work hours, did not conduct the required bed checks, and failed to provide care and services necessary to the health, safety, or welfare of Client. Furthermore, Agency has proven, by a preponderance of the evidence, that:

[52] Va. Code § 2.2-3005.
[53] Va. Code § 2.2-3005 (C)(6).
[54] Rules for Conducting Grievance Hearings, § VI. (B.)(2.).

1. Grievant engaged in the behavior described in the Written Notice.
2. The behavior constituted misconduct.
3. The Agency's discipline was consistent with law and policy.
4. There are not mitigating circumstances justifying a reduction or removal of the disciplinary action.
5. The disciplinary action of issuing the Group III Written Notice with termination was warranted and appropriate under the circumstances and it is found Agency's discipline does not exceed the limits of reasonableness.

For the reasons stated above, the Agency's issuance to Grievant of a Group III Written Notice and termination is ***UPHELD.***

APPEAL RIGHT

You may request an administrative review by EEDR within 15 calendar days from the date the decision was issued. Your request must be in writing and must be received by EEDR within 15 calendar days of the date the decision was issued.

Please address your request to:

Office of Equal Employment and Dispute Resolution
Department of Human Resource Management
101 North 14th St., 12th Floor
Richmond, VA 23219

or, send by e-mail to EDR@dhrm.virginia.gov, or by fax to (804) 786-1606.

You must also provide a copy of your appeal to the other party and the hearing officer. The hearing officer's decision becomes final when the 15-calendar day period has expired, or when requests for administrative review have been decided.

A challenge that the hearing decision is inconsistent with state or agency policy must refer to a particular mandate in state or agency policy with which the hearing decision is not in compliance. A challenge that the hearing decision is not in compliance with the grievance procedure, or a request to present newly discovered evidence, must refer to a specific requirement of the grievance procedure with which the hearing decision is not in compliance.

You may request a judicial review if you believe the decision is contradictory to law. You must file a notice of appeal with the clerk of the circuit court in the jurisdiction in which the grievance arose within 30 days of the date when the decision becomes final.

[See Sections 7.1 through 7.3 of the Grievance Procedure Manual for a more detailed explanation, or call EEDR's toll-free Advice Line at 888-232-3842 to learn more about appeal rights from an EEDR Consultant].

S/Lorin A. Costanzo

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Lorin A. Costanzo, Hearing Officer

Copy, via e-mail to:
Grievant
Agency Advocate
EDR