Issue: Group III Written Notice with Termination (Client neglect and abuse); Hearing Date: 06/13/17; Decision Issued: 07/03/17; Agency: DBHDS; AHO: Ternon Galloway Lee, Esq.; Case No. 11010; Outcome: Full Relief.

DECISION OF HEARING OFFICER

In the matter of
Case Number: 11010
Hearing Date: June 13, 2017
Decision Issued: July 3, 2017

SUMMARY OF DECISION

The Agency had found Grievant violated the rules of conduct in that he neglected and abused a client. It also determined that Grievant failed to follow the client's Behavior Treatment Plan. Then, the Agency issued Grievant a Group III Written Notice with removal. The Hearing Officer found that the Agency failed to meet its burden and rescinded the discipline. Reinstatement is ordered under the Hearing Officer's ruling here.

HISTORY

On March 31, 2017, the Agency issued Grievant a Group III Written Notice with removal. This notice asserted that Grievant violated the code of conduct by abusing and neglecting a client. Further, the group notice alleges that Grievant failed to follow the client's Behavior Treatment Plan. On April 24, 2017, this hearing officer was assigned this case by the Office of Employment Dispute Resolution (EDR).

The Hearing Officer held a telephonic prehearing conference (PHC) on April 25, 2017.[1] Based on discussions during the PHC, the Hearing Officer found that the first available date for the hearing was June 13, 2017. Accordingly, by agreement of the parties, the hearing was set for that date. On May 4, 2017, the Hearing Office issued a scheduling order addressing those matters discussed and ruled on during the PHC.

On the date of the hearing and prior to commencing it, the parties were given an opportunity to present matters of concern to the Hearing Office. They presented none. During the hearing the Hearing Officer admitted Agency Exhibits 1 through 11, Grievant's Exhibits 1 through 10, and Hearing Officer Exhibits 1 through 4. There were no objections to the admitted exhibits.

At the hearing both parties were given the opportunity to make opening and closing statements and call witnesses. Each party was provided the opportunity to cross examine any witnesses presented by the opposing party.

During the proceeding, the Agency was represented by its advocate. Grievant was represented by his advocate.

APPEARANCES

[1] This was the parties' first date available for the PHC.

Advocate for Agency
Witnesses for the Agency (2 witnesses)
Grievant
Witnesses for Grievant (2), including Grievant
Joint Witnesses (2)

ISSUE

Was the written notice with removal 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 actions against Grievant were warranted and appropriate under the circumstances. Grievance Procedure Manual ("GPM") § 5.8(2). A preponderance of the evidence is evidence which shows that what is sought to be proved is more probable than not. GPM § 9.

FINDINGS OF FACT

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

1. The Agency is a facility under the Department of Behavioral Health and Developmental Services (Department). Home #1 of the facility provides residences for intellectually disabled individuals. (Testimony of Grievant).

2. Before his termination, Grievant's job title was Direct Support Professional I. His responsibility included providing supports and services to residents. He was assigned to Home #1. Grievant had been assigned to Home #1 for at least six (6) years. In addition, during those 6 years, he had worked with Resident 1 as a support professional. He had been exposed to Resident's behaviors and garnered experience in handling those behaviors. During the 6 years he provided supports and services for Resident 1, Grievant had been assaulted by this resident on multiple occasions. (Testimony of Grievant).

On March 8, 2017, Grievant's work shift began at 6:00 a.m. Specifically, Grievant was assigned as the one on one aide for Resident 2 in Home #1. Hence during the 6:00 a.m. hour, he was sitting with Resident 2 in the room assigned to Resident 2. (Testimony of Grievant; Video viewed during the hearing multiple times[2]; A Exh. 3).

THE MARCH 8, 2017 INCIDENT

3. At one point during that hour, the lights were off in Resident 2's room. The nurse walked

[2] As noted above, the Hearing Officer viewed the DVR video multiple times during the course of the hearing. Also, the Agency provided the video on a DVR as its exhibit 11. The Hearing Officer attempted to play the DVR video that was submitted as Agency Exhibit 11, but was unable to do so. However, the Hearing Officer took sufficient notes of the video during the hearing and was able to refer to them during her deliberations. She also sufficiently viewed the video.

in and turned on the lights. Nurse had entered the room to assess and make documentations regarding an injury Resident 2 had previously sustained to his hand. Upon the nurse's entry, three staff members occupied Resident 2's room. Grievant was present. Also, Home # 1's day supervisor of the support staff was present. His title is DSP II. The third staffer was the nurse. (Testimonies of Nurse, Grievant, and DSP II).

Prior to the nurse entering Resident 2's room, she had encountered Resident 1 in the hallway. Resident 1 had been yelling and screaming in the hallway. Nurse redirected Resident 1 to his room. (Testimonies of Nurse and DSP II).

4. Directly across the hall from Resident 2's room was Resident 1's room. The support worker assigned to Resident 1 was DSP I. Hence, on March 8, 2017, DSP I was responsible for providing continuous- insight supervision of Resident 1. (G Exh. 8; A Exh. 3; Testimony of DSP I).

The evidence is insufficient to demonstrate that on the morning of March 8, 2017, DSP I provided Resident 1 with his required level of supervision. (Testimonies of Grievant, DSP II, and DSP I; Video).

5. Resident 1 had displayed agitation since the beginning of the morning shift. Specifically, several of the workers heard him fussing, yelling, and screaming up and down the hall that morning. Moreover, he had previously entered Resident 2's room behaving in a similar manner. At one point, Resident 1 was redirected to his room by Nurse.

DSP II had worked in Home #1 with Resident 1 for five (5) years. Similar to Grievant, he had learned through experience of Resident 1's behavior pattern and ways to handle his Resident 1's conduct. (Testimonies of DSP II and Grievant).

Historically, when Resident 1 began his morning with the conduct as described, his behavior is predictable. He had established a pattern which usually resulted in his behavior escalating to the point of throwing and destroying property. In addition, he was prone to harm staff and residents. In essence, the typical conduct usually signaled the escalation of dangerous behavior that would cause imminent harm to others or property. The behavior would get to the point that a "code orange" was called or restraints were used on Resident 1 to gain control of the behavior. (Testimonies of DSP II and Grievant).

Calling a "code orange" regarding Resident 1 signals that all available staff should report as designated to provide assistance in handling Resident 1's conduct. (DSP II).

Also, historically when Resident 1 is displaying aggression, the more people that come around him the more likely his combativeness and argumentativeness will escalate. (A Exh. 3, p.7).

6. While in the hallway between Resident 1's and Resident 2's rooms, Resident 1 suddenly became quiet. He reached/walked into Resident 2's room and struck Grievant in the face. The blow knocked Grievant's glasses from his face. Resident 1 then quickly departed from the area.

(Testimony of DSP II; A Exh. 3, p.3).

7. At this point, it was not certain to Grievant if Resident 1 would or was proceeding down the hall, instead of returning to his room when he left the area of Resident 2's room. Also, Resident 1's support aide – DSP I - was not in sight during this incident. (Video and Testimony of Grievant).

8. As stated above, Resident 1 had a history of causing harm to others and property when he displayed aggressive and combative behaviors. For this reason, because Grievant did not observe Resident 1's support aide in the area, he followed Resident 1 to his room in an attempt to redirect and prevent Resident 1 from proceeding down the hall and possibly harming others or property. (Testimonies of Grievant and DSP II; Video; A Exh. 3, pp. 3 and 6). DSP II (who also had at least 5 years of experience working with Resident 1) immediately followed Grievant for the same reason. But realizing that Resident 2's treatment plan required a one-on-one aide, he quickly returned to Resident 2's room. For security and the safety of staff/other residents, as DSP II was leaving Resident 1's room, he closed the room door in an attempt to prevent Resident 1 from leaving his room. (Testimony of DSP II); Video).

Once Grievant entered Resident 1's room, he found DSP I present. Grievant remained in the room to both assist and help protect DSP 1. (Testimonies of DSP I and Grievant).

9. After returning to his room, Resident 1 remained aggressive. He was yelling, screaming, combative, and uncooperative. (Testimonies of DSP II, DSP I, Grievant).

The more people in Grievant's company when he is aggressive and combative, the less likely he will destroy property. This is so because an increase in the number of people around him presents less of an opportunity for the resident to damage things. When Resident 1 returned to his room after hitting Grievant on March 8, 2017, at least two staff members were present. Resident 1 did not destroy property during the March 8, 2017 incident. (Testimony of DSP II).

Moreover, the light was not working in Resident 1's room at this time. (Testimonies of Grievant and DSP II).

With both DSP I and Grievant present, Resident 1, pushed pass DSP I, fell into a dresser, and cut his lip. He began to bleed. Grievant attempted to help Resident 1, but the resident remained combative. Also, to address the bleeding, Grievant went out of the room to get a towel to be used to assist Resident 1. He also determined that Nurse had left the room directly across from Resident 1's room. The nurse had apparently returned to the nurse's desk to make documentation of what she had assessed regarding Resident 2. Grievant wet the towel to apply to Resident 1's injury. He then called for the Nurse to assess Resident 1. From the time Grievant first witnessed the injury to the time he telephoned for the nurse, no more than nine (9) minutes had lapsed. (Testimony of Grievant; A Exh. 3. pp. 2, 6-7)

10. At some point during the incident, when Grievant entered Resident 1's room, Grievant asked Resident 1 questions to the effect of "Why did you hit me?"; "Why are you fussing?" "What's wrong?". Grievant remained calm after being assaulted by Resident 1 and spoke to

Resident 1 in a calm voice. DSP II and DSP I did not observe Grievant batter Resident 1. The evidence establishes Resident 1 was not hit by Grievant. Nor did Grievant put his hands on Resident 1 as "payback" after the assault. The evidence shows that after Resident 1 fell and injured his lip, DSP 1 and Grievant encouraged Resident 1 to remain calm and to sit down.

When Resident 1 is in an aggressive and combative state, staff is permitted to inquire why he is behaving in that manner.

(Testimonies of DSP II, DSP I; A Exh. 3, pp. 2,4).

11. During the incident on March 8, 2017, Resident 1 was not isolated. (Testimonies of Grievant and DSP I).

12. During a portion of the incident, Nurse was present, but her attention was focused on treating Resident 2. Therefore, Nurse was unable to provide an accurate account of the entire incident. Hence, the nurse does not know how Resident 1 injured his lip. (Testimony of Nurse; A Exh. 3, p. 2).

13. A video presented as evidence by the Agency and viewed by the Hearing Officer that purports to show the incident fails to provide a visual recording of the entire situation. For instance, the recording does not show who closed the door to Resident 1's room once Grievant and DSP II entered it. Neither does the recording show how Resident 1 was injured.

14. The video does not show the object of Resident 1's physical aggressive gesture inside Resident 2's room. (Video; Testimony of Investigator).

15. Further, the video submitted is without sound. Thus, any conversations engaged in by staff and or Resident 1 and staff were not provided by the video. (A Exh. 11; Video).

Lighting in the video is dim. (Viewing of Video during the hearing).

16. The video fails to corroborate Resident 1's claim that Grievant hit Resident 1. (Video).

17. Resident 1 carries a diagnosis of mild intellectual disability. (A Exh. 3, p.1; Testimony of Grievant).

Also, Resident 1 has a history of making false allegations. His treating psychologist characterized Resident 1 as having a history of misinterpreting the environment around him and making false allegations. Resident 1's psychologist indicates that those false statements can include alleging that someone harmed him. Resident 1 made inconsistent statements regarding how his lip was injured on March 8, 2017. Under one account, he fell and hit his lip. Under another, he contends he was hit by Grievant/Grievant "beat his ass." (A Exh. 3, pp. 2, 24).

18. Over the several years Grievant had worked with Resident 1, Grievant had been hit by this resident on several occasions, Grievant did not interpret this behavior as Resident 1 targeting him. Further, on March 8, 2017, Grievant did not hear Resident 1's comments that may have

been heard by other staff and suggested to the other staff that Grievant was targeted by Resident 1. (Testimony of Grievant).

INVESTIGATION

19. Resident 1 alleged that Grievant hit him in the mouth and Resident 1 fell and injured himself. Thus an investigation ensued. The investigator found that Grievant had not followed Resident 1's Behavior Treatment Plan (BTP). Further, the investigation concluded that Grievant failed to immediately notify a nurse, doctor, or nurse practitioner of Resident 1's injury. (A Exhs. 3).

20. During the course of the investigation, Investigator interviewed seven employees of the Agency and Resident 1. Each employee was interviewed once, with the exception of DSP I. He was interviewed twice, once on March 9, 2017, and again on March 21, 2017. In addition, the investigation indicates that all persons except DSP I were interviewed solely by the investigator. However, during DSP I's second interview, investigator brought along a second interviewer – the facility director. (A Exh. 3, pp. 4 and 7). This second interview occurred almost two weeks after the incident.

21. Differences exist between the investigator's first interview and what he reports as statements regarding a second interview with DSP I.

For example, the second interview reportedly indicates that Resident 1 became more upset because Grievant had been yelling at Resident 1 telling him to lie back down and go to sleep. The first interview as reported is silent regarding this subject. (A Exh. 3, pp. 4 and 7).

In addition, investigative notes indicate that during the second interview, DSP I told Grievant several times to call the nurse. A review of the investigative notes of the first interview indicates that DSP I asked "**someone** to call the nurse." (A Exh. 3, pp. 4 and 7 (emphasis added)).

Further, the investigative report states that during the second interview, DSP I told Grievant that "it [Resident 1's injury] was Grievant's fault because Grievant had been chasing Resident 1." A review of the investigator's first interview with DSP I shows the following pertinent dialogue regarding DSP's thought on whether Grievant caused the injury:

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Question by Investigator:	What was [Grievant's] demeanor after being hit?
Answer by DSP I:	He was frustrated and upset.
Question by Investigator: [Grievant's]	Do you feel [Resident 1's] fall was a direct result of reaction to being hit?
Answer by DSP I:	I can't really say, probably so.

(A Exh. 3, p. 4).

22. The Hearing Officer finds that the phrase "probably so" fails to indicate certainty.

23. Regarding the Investigative report, the Hearing Officer finds that the questions asked by the one interviewer to DSP I on March 9, 2017, are set forth in the report along with the exact responses of DSP I. (A Exh. 3, pp. 4-5).

However, the interview questions asked by the two interviewers on March 21, 2017, are not listed in the report. Neither are the verbatim responses of DSP I. (A Exh. 3, p. 7). Hence the context of the questions and answers from the second interview are not provided.

GROUP III WRITTEN NOTICE

24. After the investigation concluded and Investigator made his determination, management issued Grievant a Group III Written Notice with removal. (A Exh. 1). In the group notice issued on March 31, 2017, the Agency contends that Grievant neglected and abused Resident 1 because Grievant failed to follow Resident 1's BTP. Also, the Agency contends that Grievant failed to follow agency policy that required Grievant to immediately notify the nurse of Resident 1's injury. (A Exh. 1; Testimony of Investigator).

A. Alleged BTP violations

25. The agency had adopted a Behavior Treatment Plan (BTP) for Resident 1. The BTP targeted Resident 1's aggression, attempts to be aggressive, disruptive behavior, property destruction, and insomnia. Observed aggressive behaviors of Resident 1 included hitting, kicking, pushing, shoving , or throwing objects at others with the potential of harming others. Disruptive behaviors noted in the BTP include shouting, arguing, threatening, cursing, yelling, screaming, and name-calling. In addition, property destruction noted in the BTP included throwing items, shoving/overturning furniture, breaking things/knocking things off tables, kicking or banging on walls, doors, windows, or tables. (A Exh. 7).

26. The application of the BTP updated on January 5, 2017, could vary weekly. For instance, at times staff was expected to employ some procedures from a prior BTP. Other times, staff was expected to apply procedures set forth on the BTP dated January 5, 2017. (Testimony of DSP II, and shift supervisor).

The evidence fails to establish by a preponderance of the evidence that Grievant failed to follow BTP in place on March 8, 2017.

27. There are a minimum of 4 staff persons working during the morning and afternoon shifts at Home # 1. Four residents are housed in the home. When a resident is aggressive or combative there is a practice in the home that other staff may assists the staff person assigned to the resident to calm him down. Resident 1 was combative and aggressive the morning of March 8, 2017. (Testimony of DSP 1).

28. The Agency contends that Grievant failed to follow the BTP in several ways. (A Exh. 3, pp. 9-10).

29. First, the Agency contends that Grievant failed to comply with item #4 of the Response – contingent procedures. Item 4 reads as follows:

> If [Resident 1] appears to be agitated or disruptive, staff will speak to him in a calm, quiet voice, attempt to assess the source of his irritation and assist him in resolving any identified problem. He may resume his normal activities when he feels he is ready to do so.

(A Exh. 7, p. 5).

30. Second, the Agency contends that Grievant failed to follow item # 9 of the Response – contingent procedures. This procedure reads as follows in pertinent part:

> Staff will not get into extended discussions and debates with [Resident 1], as this only escalates his outburst. Staff will refrain from engaging in any type of reprimanding, arguing and refusals to assists….

(A Exh. 7, p. 5).

31. Third, the Agency contends that Grievant failed to follow item #11 of the Response – contingent procedures. This procedure reads as follows in pertinent part:

> [I]n general, staff should not comment upon his behavior and should avoid saying things like, "Stop that," or "That's inappropriate." …

(A Exhs. 3 and 7, p. 5).

As mentioned previously, when Resident 1 is aggressive, staff is allowed to ask Resident 1 "why he has behaved in a certain way." (Testimony of DSP I).

32. Fourth, the Agency contends that Grievant failed to follow item #13 of the Response – contingent procedures. This procedure reads as follows in pertinent part:

> In the event that [Resident 1] appears to be targeting a specific staff member and redirection techniques have been ineffective, it is important this particular staff member first try to switch assignments/locations with another staff member in the home….

(A Exhs.3 and 7, p. 5)

33. Agency also contends the BTP was violated because Grievant secluded Resident 1 when the door was shut. It also contends that Grievant's actions were retaliatory.

The Agency contends Grievant also violated Environment and Adaptive Behavior Steps under the BTP. Specifically, the Agency alleges that Grievant violated item 2 of these steps which instructs staff as noted below:

> Avoid power struggles. Effectively listen to what [resident 1] is requesting and honor his request within reason. When the request cannot be immediately honored, provide options.

(A Exh. 7, p. 2).

In addition, the Agency contends that Grievant violated item # 4 of these steps which provide in pertinent part the following:

> Interactions: When working with [Resident 1], staff will use a calm, interactive voice tone. Staff will ensure their interaction with [Resident 1] are that of a supportive helper who recognizes that [Resident 1] needs external assistance to reduce anxiety and stress.
>
> ***
>
> f. It is critical to avoid statements such as "stop," you need to leave the room," or closing the door in a manner that [Resident] may miss-interpret as closing him out.

(A Exh. 7, p. 3).

B. Alleged Policy violations

34. Next, the Agency contends that Grievant also failed to follow Agency policy set forth in its Programming Guideline Policy 7, Section 6. That specific policy section is titled "Reporting Health Concerns to Medical and Nursing Personnel" (Policy 7). Specifically the agency contends that grievant failed to immediately report to the nurse the injury of Resident 1. (A Exh. 1).

POLICIES

A. Policy 7

35. Policy 7 requires residential services staff such as Grievant to immediately notify a nurse, physician, or nurse practitioner of any changes in condition, injuries, accidents, illness, or other health concerns of a resident so that a prompt assessment can be made and medical treatment obtained if necessary. This policy also list specific conditions and events regarding residents that staff are mandated to report. For purposes of this grievance proceeding, relevant conditions and events required to be reported by the policy are as noted below:

Bruises;

wounds
Reddened areas or swelling
Skin breakdown
Blunt force to head with or without apparent injury
Injuries to mouth area
Complaint of injury
Complaint of pain
Falls
Changes in condition, apparent or perceived discomfort or any concern regarding health status
Other complaints from individuals or any health related staff concerns
Headaches
Changes in gait
limping

(A Exh. 6, pp. 2-3)

As noted previously here, Resident 1 injured his lip on March 8, 2017, after falling. Grievant and DSP I witnessed the injury. (Testimonies of Grievant and DSP I; A Exh. 3).

36. Policy 7 continues and provides in pertinent part the following:

> If after calling [reporting], a staff member notes that Nursing or Physician follow-up has not occurred he/she should repeat the notification through Reception and also notify the Residential Manager, Support Coordinator, or Shift Supervisor. The length of time a staff member should wait before repeating the call to the Nurse or Physician depends on the individual's condition and the staff member's judgment. However, in every case, notification should be repeated if the person's health issue has not been addressed within 30 minutes from the initial notification.

(A Exh. 6, p. 3).

B. Departmental Instruction 201, Section 201-3

37. In pertinent part Departmental Instruction 201, section 201-3 defines abuse as follows:

> [A]ny act or failure to act by an employee or other person responsible for the care of an individual in a department facility that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused her might have cause physical or psychological harm, injury or death to a person receiving care or treatment for mental illness, mental retardation or substance abuse.

(A Exh. 4, p. 1).

38. DI 201, at 201-3 continues by giving several examples of abuse. Examples pertinent to this case are "use of language that demeans, threatens, intimidates, or humiliates the person," and "use of restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan."

(A Exh. 4, p. 1).

39. In pertinent part, Departmental Instruction 201, section 201-3 defines neglect as follows:

> This means the failure by a person, program, or facility operated, licensed, or funded 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 a person receiving care or treatment for mental illness, mental retardation, or substance abuse.

(A Exh. 4, p. 2).

OTHER CONSIDERATIONS

40. Grievant has no prior disciplinary record. (Testimony of Grievant).

41. The Administrator/Supervisor was not present and therefore was not a witness to the incident on March 8, 2017, as it unfolded. Neither was the investigator. (Testimony of Administrator; A Exh. 3).

42. The evidence does not establish that either the investigator or the administrative supervisor ever worked directly with Resident 1. (Testimonies of Investigator and Administrator).

DETERMINATIONS AND OPINION

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. This comprehensive legislation includes procedures for hiring, promoting, compensating, discharging and training state employees. It also provides for a grievance procedure. The Act balances the need for orderly administration of state employment and personnel practices with the preservation of the employee's ability to protect his/her rights and to pursue legitimate grievances. These dual goals reflect a valid governmental interest in, and responsibility to, its employees and workplace. *Murray v. Stokes,* 237 VA. 653, 656 (1989).

Va. Code § 2.2-3000 (A) sets forth the Commonwealth's grievance procedure and provides, in pertinent 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 resolution of employment disputes which may arise between state agencies and those employees who have access to the procedure under § 2.2-3001.

In disciplinary actions, the agency must show by a preponderance of evidence that the

disciplinary action was warranted and appropriate under the circumstances.[3]

To establish procedures on Standards of Conduct and Performances for employees of the Commonwealth of Virginia and pursuant to § 2.2-1201 of the *Code of Virginia*, the Department of Human Resource Management promulgated Standards of Conduct Policy No. 1.60 (Policy 1.60). The Standards of Conduct provide a set of rules governing the professional and personal conduct and acceptable standards for work performance of employees. The Standards serve to establish a fair and objective process for correcting or treating unacceptable conduct or work performance, to distinguish between less serious and more serious actions of misconduct and to provide appropriate corrective action.

Under the Standards of Conduct, Group I offenses are categorized as those that are less severe in nature, but warrant formal discipline; Group II offenses are more than minor in nature or repeat offenses. Further, Group III offenses are the most severe and normally a first occurrence warrants termination unless there are sufficient circumstances to mitigate the discipline. *See* Standards of Conduct Policy 1.60.

On Mach 31, 2017, management issued Grievant a Group III Written Notice with removal for the reasons stated in the above section. The Hearing Officer examines the evidence to determine if the Agency has met its burden.

I. Analysis of Issue(s) before the Hearing Officer

Issue: Whether the discipline was warranted and appropriate under the circumstances?

The Agency contends Grievant abused and neglected Resident 1 by failing to comply with Resident 1's Behavior Treatment Plan and by failing to comply with Agency Policy 7.

A. Behavior Treatment Plan

1. Response Contingent Procedures 4, 9, 11, and 14

First, the Hearing Officer considers the allegation that Grievant failed to follow Resident 1's Behavior Treatment Plan (BTP) and therefore abused/neglected the resident. More particularly, the Agency contends that Grievant violated Response Contingent Procedures (contingent procedures) 4, 9, 11, and 13 of the BTP. The relevant provisions of the named procedures are found in the "Findings of Fact" here.

Regarding the Agency's allegations about these contingent procedures, the evidence demonstrates that Grievant, DSP II and DSP I were eye witnesses to all or a portion of the incident. They describe Grievant as remaining calm even after Resident 1, surprised Grievant by assaulting Grievant with such force that Resident 1 knocked off Grievant's glasses. In addition, DSP I testified that when a resident is combative, staff is permitted to inquire of the resident "why he is behaving in that manner." Grievant's testimony and other evidence of record

[3] Grievance Procedural Manual §5.8

establish that Grievant followed the contingent procedures. Grievant's testimony revealed that after he directed and followed Resident 1 to his room, Grievant asked Resident 1 questions to the effect of "why are you fussing; what's wrong, and why did you (Resident 1) hit me."

The Hearing Officer had an opportunity to observe DSP II's, DSP I's and Grievant's demeanors and found their testimony credible and consistent with other evidence of record. She also finds Grievant's post-assault inquiry and the manner in which it was conducted consistent with the contingent procedures mentioned here.

In sum, the Hearing Officer is not persuaded that Grievant violated the mentioned contingent procedures. That is, the Agency has failed to meet its burden and demonstrate that Grievant violated Contingent Procedure 4. Grievant remained calm and attempted to assist Resident 1. He did not retaliate and hit Resident 1 back. This is so even though, Resident 1 remained combative an uncooperative. Likewise, the Agency failed to meet its burden and demonstrate Grievant violated Contingent Procedure 9. In other words, after giving great thought to the evidence, the Hearing Officer is not persuaded that Grievant engaged in any extended discussions/debates with Resident 1. Moreover, the Hearing Officer finds the Agency has not demonstrated that Grievant violated Contingent Procedure 11. Clearly, as mentioned before, Grievant's questions to Resident 1 were appropriate and permitted by Agency practice. Without doubt, the evidence shows that Grievant tried to assist Resident 1, but the resident was uncooperative.

In the same was as the Agency has not demonstrated Grievant violated contingent procedures 4, 9, and 11, the evidence is also insufficient to show that Grievant violated Contingent Procedure 13. As previously mentioned, this procedure addresses actions a staff person should employ when a resident's aggression is directed toward that particular employee. Grievant testified credibly that he was not aware of being the target of Resident 1's aggression on March 8, 2017. Without knowing he was a target, Grievant would not have reasonably switched assignments/locations with another staff member in the home as directed by the procedure. In addition, a close reading of the policy permits a targeted staff member to first try redirection techniques. To this point, indeed, the evidence shows that Grievant was attempting to redirect Resident.

Accordingly considering the above regarding contingent procedure 13, the Hearing Officer finds that first Grievant was unaware that he was the target of Resident 1's aggression. Therefore, application of the "switching technique" was not triggered. Second, assuming that Grievant knew he was targeted – which the Hearing Officer has found was not the case – the policy permits the staff person to first attempt redirection. The evidence shows that from the time Grievant was battered by Resident 1 until the nurse was called, about 9 minutes lapsed. During that brief time period, Grievant did attempt to redirect Resident 1, by at least getting the resident to return to his assigned room.

For the reasons noted here, the Agency has failed to meet its burden and demonstrate that Grievant violated the contingent procedures referenced above.

2. Environmental and Adaptive Behavior Steps 2 and 4

The Agency also contends that Grievant violated certain Environmental and Adaptive Behavior Steps (Behavior Steps) under the BTP. Particularly, the Agency contends Grievant violated # 2 by engaging in a power struggle. The evidence falls short of showing that Grievant engaged in such a battle. As noted above, Grievant, as permitted by Agency practice, attempted to understand the reason for the behavior. Also, Grievant's questioning (for example, "What is wrong?') indicated he was receptive to listening to Resident 1; however, Resident 1 continued to fuss and scream. He remained aggressive, and uncooperative. At the same time, the evidence clearly demonstrates that Grievant remained calm and tried to assist Resident 1. Grievant even retrieved a wet towel to aid in stopping Resident 1 from bleeding. What is more, the evidence shows that even though Grievant was not assigned to provide services to Resident 1 on March 8, Grievant was the staff person to call for the nurse in less time than 10 minutes after the injury occurred.

Hence the Hearing Officer is not persuaded that Grievant violated Behavior Step #2.

Similarly, the Hearing Officer finds that the Agency failed to meet its burden and demonstrate that Grievant violated Adaptive Behavior 4. In part, this behavior step instructs staff to remain calm when working with Resident 1. As noted earlier, the evidence clearly shows Grievant did so.

Moreover, the Agency claimed Grievant violated Adaptive Behavior 4 because Grievant closed Resident 1's door after the resident returned to his room. Further, the Agency contends that Grievant took this action to seclude the resident and as retaliation for Resident 1's assault on Grievant. Of note DSP II testified credibly that after Grievant was struck by Resident 1, DSP II also followed Grievant into Resident 1's room. Once DSP II realized there needed to be a staff person in the room across the hall, he departed Resident 1's room and closed the door behind him. The evidence demonstrates that this action was taken for security reasons because when Resident 1 displays aggression and combative behaviors, his conduct usually escalates to the extent that an imminent threat of harm to others and property exists.

Considering the evidence, the Hearing Officer finds that assuming the action of closing the door was a seclusion (which the Hearing Officer finds was not the case under the facts of this case) this action was not taken by Grievant. In addition, staff had to weigh the danger of 1) leaving Resident 1's door open and subjecting others and property to immediate harm with 2) separating Resident 1 from others for safety reasons. Hence, the Hearing Officer finds the action taken by DSP II to close Resident 1's door was reasonable and under the circumstances did not violate Behavior Step 4. Further, she finds that closing the door did not place Resident 1 in seclusion. This is so because the evidence shows that even with the door closed, two staff persons remained in the room – DSP I and Grievant - as well as the resident. In sum, the definition of seclusion is not met in this case, and alternatively exigent circumstances made the seclusion issue inapplicable.

B. Policies

1. Programming Guideline Policy 7, Section 6

Under Programming Guideline Policy 7, Section 6 (Policy 7), staff are required to immediately report certain conditions and events to a Nurse, Nurse Practitioner, or Doctor. In this case, the Agency claims that Grievant violated the policy by not immediately reporting Resident 1's condition or event.

The Hearing Officer has considered the totality of the circumstances as discussed previously in this decision. Having done so, she is not persuaded that Grievant's report of Resident 1's injury to the Nurse after about 9 minutes had lapsed violated the policy. Of note during that brief time period, Grievant attempted to assist the resident. He made recognition of the fact that the nurse was no longer across the hall. And he retrieved a towel, wet it, and attempted to stop Resident 1's bleeding.

In addition, the Hearing Officer has considered and finds instructive the Policy 7's provision below regarding what is contemplated by "immediate action." That provision reads as noted below:

> If after calling [reporting], a staff member notes that Nursing or Physician follow-up has not occurred he/she should repeat the notification through Reception and also notify the Residential Manager, Support Coordinator, or Shift Supervisor. The length of time a staff member should wait before repeating the call to the Nurse or Physician depends on the individual's condition and the staff member's judgment. However, in every case, notification should be repeated if the person's health issue has not been addressed within 30 minutes from the initial notification.

Now, the Hearing Officer considers the relevant particulars of this case. The evidence shows that Grievant immediately took action once he learned of Resident 1's injury. He was proactive and tried to assist, but as the evidence establishes, Resident 1 was not cooperative. In addition, Grievant called the nurse within 9 minutes of the injury. This is so even though, he was not the staff person assigned to Resident 1 on March 8, 2017.

The provision of Policy 7 noted above allows the nurse or physician that is first notified of a condition or event (such as occurred in this case) up to 30 minutes to respond. If there is no response, the nurse or physician is notified again so that he/she can follow-up and assess the situation for any treatment. Accordingly, in effect, the nurse or physician is afforded at least 30 minutes to respond to a situation such as occurred in this case.

Here, Grievant notified the nurse within minutes. This period of time was less than one-third of the time that in effect is permissible under agency policy for a nurse or physician to respond under similar circumstances.

Accordingly, the Hearing Officer finds Grievant took active steps without delay once he was aware of the resident's injury. In addition, he only permitted a brief period of time to go by

before the nurse was summons to assess the injury. Hence, the Agency is not able to meet its burden and show Grievant violated Policy 7. Further, the Hearing Officer has determined the 30 minutes response period permitted for nurses and physicians to respond corroborates that Grievant acted with urgency and lends supports her finding.

2. Policy 201-3

The Agency also claims that Grievant violated Department Instruction 201, section 201-3 (Policy 201-3) pertaining to abuse and neglect of residents. Those polices are set forth above in "Findings of Fact" numbered 38 and 39. .

For reasons already stated here, the Hearing Officer finds the evidence is insufficient to show that Grievant abused Resident 1, neglected him, or failed in any way to provide services to him. Hence, the Agency has not met its burden and shown Grievant neglected and or abused Resident 1.

C. Other

Further, the Hearing Officer has given thought to the testimonies of the Investigator and the Administrator and their conviction that Grievant violated the BTP and policies discussed here. Neither of these witnesses were eye witnesses to the incident. In addition, the evidence does not establish that either has worked with Resident 1. The Hearing Officer also observed the demeanor of these Agency witnesses. After consideration of all of the above, the Hearing Officer found it appropriate to give more weight to testimony provided by DSP II and Grievant. This testimony contradicted the contentions of the Agency witnesses. Of note, both DSP II and Grievant had considerable experience working with Resident I and the daily practices regarding Resident 1's behavior treatment. In addition, they were able to provide an eye witness account of the March 8 incident and the associated conversations.

In addition, the Hearing Officer finds that other evidence of record fails to substantiate the Agency's position. For example, DPS II who is the shift supervisor of staff testified that the BTP of Resident 1 was prone to change weekly. The Hearing Officer found this testimony credible. This evidence indicates that the BTP provisions the Agency contends were not followed by Grievant may not have been in effect. This is so because the BTP the Agency contends should have been implemented were last updated January 2017. The credible testimony of the shift supervisor of the staff demonstrates that Resident 1's BTP was prone to change on a weekly basis. This, on March 8, 2017, Resident 1's BTP may have differed from the one updated in January 2017.

What is more, the evidence does not establish that DSP I provided Resident 1 with continuous and in sight supervision on March 8, 2017. Also the evidence demonstrated that staff was permitted to work together to address the conduct of an aggressive/combative resident. The Hearing Officer finds that these two factors support Grievant's position that he was not acting in a retaliatory manner, but rather assisting, redirecting, and protecting staff and others. Moreover, the Hearing Officer notes her consideration of evidence showing that (i) the light in Resident 1's room was not working and (ii) Resident 1 had a history of falsely accusing others of harming him.

The Hearing Officer is also cognizant of the entire investigative report which includes a summary of the Agency's second interview with DSP I. Along with other evidence of record, the Hearing Officer has given attention to the second interview the investigator conducted with DSP I. A summary of this second interview noted that DSP I blamed Grievant for the Resident's 1 fall and asserted that Grievant was chasing after Resident I. The Hearing Officer was also attentive to disparities between this reported interview and others conducted by the investigator. For example, DSP I was the only person interviewed twice during the investigation. Also, DSP I's second interview was conducted almost two weeks after the incident. All the other interviews were conducted closer in time to when the incident occurred. In addition, the verbatim questions asked during the second interview and the answers provided did not appear to be set forth in the investigative report as was the case with all other interviews. Further, during the second interview, DSP I was interviewed by two individuals – the investigator and upper management. All other interviews were conducted only by the investigator.

In sum, for all the reasons noted, the Hearing Officer finds the Agency is unable to meet its burden and show the discipline was warranted and appropriate.

Because the Agency cannot show that Grievant violated Agency policies or Resident 1's BTP as alleged, the discipline is inconsistent with law or policy.

II. Decision and Order

Therefore, for the reasons stated here, the Hearing Officer rescinds the Agency's discipline.

Moreover, the Agency is ordered to take the following action:

1. rescind the Group III Written Notice with termination;

2. pay full back pay for the period Grievant has been separated from his job (back pay is to be offset by interim earnings);

3. appropriately restore other benefits and seniority;

4. reinstate Grievant to his former position or, if occupied, to an equivalent position.

APPEAL RIGHTS

You may file an **administrative review** request within **15 calendar days** from the date the decision was issued, if any of the following apply:

1. If you believe the hearing decision is inconsistent with state policy or agency policy, you may request the Director of the Department of Human Resource Management to review the decision. You must state the specific policy and explain why you believe the decision is inconsistent with that policy. Please address your request to:

Director
Departmental of Human Resource Management
101 N. 14th St., 12th Floor
Richmond, VA 23219
or, send by fax to (804) 371 – 7401, or e-mail.

2. If you believe that the hearing decision does not comply with the grievance procedure or if you have new evidence that could not have been discovered before the hearing, you may request that EDR review the decision. You must state the specific portion of the grievance procedure with which you believe the decision does not comply. Please address your request to:

Office of Employment Dispute Resolution
Department of Human Resource Management
101 N. 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 may request more than one type of review. Your request must be in writing and must be **received** by the reviewer within 15 calendar days of the date the decision was issued. You must provide a copy of all of your appeals to the other party, EDR, 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.

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.[4]

Entered this 3rd day of July, 2017.

_____
Ternon Galloway Lee, Hearing Officer
cc: Agency Advocate/Agency Representative
Grievant/Grievant's Advocate
EDR's Director

[4] Agencies must request and receive prior approval from EDR before filing a notice of appeal.