Issue: Group III Written Notice with termination (client neglect); Hearing Date: 08/28/03; Decision Issued: 09/08/03; Agency: DMHMRSAS; AHO: David J. Latham, Esq.; Case No. 5786

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 5786

Hearing Date: August 28, 2003
Decision Issued: September 8, 2003

APPEARANCES

Grievant
Representative for Grievant
One witness for Grievant
Registered Nurse III
Representative for Agency
Six witnesses for Agency
Observer for EDR

ISSUES

Did the grievant's actions warrant disciplinary action under the Commonwealth of Virginia Standards of Conduct? If so, what was the appropriate level of disciplinary action for the conduct at issue?

FINDINGS OF FACT

The grievant filed a timely appeal from a Group III Written Notice for neglecting a resident.[1] As part of the disciplinary action, grievant was removed from state employment. Following failure of the parties to resolve the grievance at the third resolution step, the agency head qualified the grievance for a hearing.[2] The Department of Mental Health, Mental Retardation and Substance Abuse Services (hereinafter referred to as "agency") has employed the grievant as a certified nurse assistant (CNA) for 13 years.

Section 201-1 of MHMRSAS Departmental Instruction 201 on Reporting and Investigation Abuse and Neglect of Clients states, in pertinent part: "The Department has zero tolerance for acts of abuse or neglect."[3]

At about 7:00 p.m. on March 5, 2003, grievant was in the tub room of the ward to which she was assigned. The tub room is adjacent to the bathroom and includes a large bathtub, a separate shower stall area, a bidet, a storage cabinet, linen shelf, trashcan, clothes hamper, several chairs and a movable shower chair.[4] An 84-year-old female client with Alzheimer's Disease was sitting in a chair in the open area between the tub and shower stall. Grievant had assisted the client in disrobing so that the client could give herself a sponge bath. There are two versions of what next occurred, which will be discussed in the Opinion section of this Decision.

Subsequent to the incident, grievant summoned the registered nurse in charge to the tub room to examine the client because she had slipped. The nurse found the client alone in the tub room, sitting in the chair, and crying. The patient told the nurse, "I must have fallen." Grievant interjected, "You did not fall, I caught you." The nurse conducted a five-to-ten minute, head-to-toe assessment and found only a tiny (0.1cm) abrasion on the client's left earlobe. Shortly thereafter, the nurse asked the on-duty physician to come to the ward

---

[1] Exhibit 6. Written Notice, issued June 3, 2003.

[2] Exhibit 7. Grievance Form A, filed July 1, 2003.

[3] Exhibit 3. Departmental Instruction 201(RTS)00, *Reporting and Investigating Abuse and Neglect of Clients*, revised April 17, 2000. The definition of abuse is: "Abuse means any act or failure to act by an employee or other person responsible for the care of an individual that was performed or was failed to be performed knowingly, recklessly or intentionally, and that caused or might have caused physical or psychological harm, injury or death to a person receiving care or treatment for mental illness, mental retardation or substance abuse." The definition of neglect is: "Neglect means failure by an individual, program or facility responsible for providing services to provide 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."

[4] *See* Exhibit 1 for diagram and photographs of the tub room.

and examine the patient. At about 9:00 p.m., the physician assessed the patient and noted only an excoriation (superficial scratch) on the tip of the left earlobe.[5]

At 9:00 p.m., the registered nurse documented the client's status noting:

> [Client] Continue to deny that she hit her head; but appears confused as to what actually happen. Each time she is asked gives a different version of what happen and what she was doing when the event occurred.[6] (sic)

The following morning, the nurse on duty at that time noted that the client complained of left hip discomfort stating, "I hurt it when I fell."[7] The nurse did not find any redness or bruising on the left hip. In the afternoon, the client told the registered nurse about her hip discomfort stating, " I must have hurt it when I fell yesterday to the floor."[8] The nurse then told the client that it had been reported that she did not fall the day before. The client repeated that she had fallen, and then added that the door had knocked her to the floor as it opened. She stated that, "That girl did not know I was standing behind the door. When she opened the door, the door knocked me to the floor."[9]

The nurse then reported the incident as a possible abuse or neglect incident. Following investigation, the agency issued the Written Notice and removed grievant from employment.

APPLICABLE LAW 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 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).

Code § 2.2-3000 sets forth the Commonwealth's grievance procedure and provides, in pertinent part:

---

[5] Exhibit 1, p.31. Physician Progress Notes, March 5, 2003, 9:00 p.m. See *Encyclopedia and Dictionary of Medicine and Nursing* for definition of excoriation.
[6] Exhibit 1, p. 33. Registered Nurse's Interdisciplinary Note, March 5, 2003, 9:00 p.m.
[7] Exhibit 1, p. 36. Nurse's Interdisciplinary Note, March 6, 2003, 7:00 a.m.
[8] Exhibit 1, p. 35. Registered Nurse's Interdisciplinary Note, March 6, 2003, 4:00 p.m.
[9] Exhibit 1, p. 14. Registered Nurse's witness statement, March 10, 2003.

> 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 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.[10]

To establish procedures on Standards of Conduct and Performance 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 effective September 16, 1993. 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. Section V.B.3 of the Commonwealth of Virginia's Department of Personnel and Training Manual *Standards of Conduct* Policy No. 1.60 provides that Group III offenses include acts and behavior of such a serious nature that a first occurrence normally should warrant removal [from employment].[11]

The evidence in this case does not support a finding that the client was abused, as that term is defined in Departmental Instruction (DI) 201. Although the client sustained a superficial scratch, there is no evidence that the grievant caused this injury, and if she did, there is no evidence that she caused it knowingly, recklessly or intentionally. Further, although the client complained of hip discomfort the following day, there was no radiological or clinical evidence of any injury. Similarly, there is no evidence to support a conclusion that the incident amounted to neglect. The grievant did not fail to provide treatment, care or service necessary to the health, safety or welfare of the client. The unfortunate accident appears to be attributable in part to the client's advanced age, physical infirmity, and inability to react quickly.

The agency acknowledged that what occurred was accidental.[12] Discipline was issued primarily because the agency concluded that grievant falsified her version of the incident, thereby violating DI 201 by deliberately

[10] § 5.8, EDR Grievance Procedure Manual, effective July 1, 2001.
[11] Exhibit 7. DHRM Policy No. 1.60, Standards of Conduct, September 16, 1993.
[12] The Hospital Director so testified at the hearing.

misstating facts when questioned in an investigation.[13] This offense is subject to discipline up to and including termination of employment. However, to sustain such discipline, the agency must demonstrate, by a preponderance of evidence, that grievant did commit the offense. There are two conflicting versions of what actually caused the patient to fall.

The client initially told the registered nurse and a nurse on another shift that she had fallen. About 24 hours later, she changed her story, contending that she was, "trying to go to the other room to get a wash cloth…"[14] and that the door opened and knocked her down. Grievant contends that she was tending to a second client about 6-8 feet away when she heard the first client exclaim, "Oops!" She turned and saw the client losing her balance and attempting to catch herself on the edge of the bathtub. Grievant states that she quickly took two or three steps toward the client, put her own arms under the client's arms, and caught/lowered her to the floor.

Investigator's Summary

While the agency's investigator conducted a reasonably thorough investigation, the evidence gathered does not support several conclusions in the Investigator's Summary. The client's only observable injury was a superficial scratch on the earlobe. There is no evidence to show that the client's ear was scratched as a result of the fall; it could have been scratched at an earlier time and noticed only when the nurse conducted her post-fall examination of the client. Similarly, although the client later complained of hip discomfort, there is no evidence that such discomfort was attributable to the fall. At this client's advanced age, it is equally possible that her hip discomfort upon waking was related to arthritis, or from having slept in an unusual position. It appears highly unlikely that an 84-year-old person could be roughly knocked to a tiled floor and sustain no more than a superficial scratch on the ear. However, even if one assumes that both the scratch and hip discomfort did result from the fall, it is impossible to determine the etiology of either symptom.

The agency suggests that because both the left ear and left hip were involved, the client was more likely to have been hit by the door. This premise is not necessarily correct. If the client had been hit hard enough to knock her down, it is likely that she would have fallen backward. A scratch to her ear would have been sustained only if the door hit her head; the client has consistently

[13] Exhibit 3. Section 201-8, p. 11. Departmental Instruction 201 (RTS)00, *Ibid.* The Hospital Director noted that if the grievant had left the patient unattended in the tub room, it would constitute neglect. *See* Exhibit 4. Standard Operating Procedure 280-Z, *Accountability for Patients in Units*., April 16, 2002. Item 5 states, "While patients are in bathrooms/showers, a staff member will be stationed in the area to monitor the patient's activities." However, grievant denies leaving the tub room and there is no evidence to rebut her testimony on this point. One could infer from the client's version that grievant may have left the room but as discussed below, the client's memory of this event is at best hazy.

[14] Exhibit 1, p. 14. *Ibid*.

denied any head pain and showed no evidence of head injury. It is difficult to visualize how a blow from a door hard enough to knock one down could cause a superficial scratch on the ear without also causing significant bruising on the ear or side of the head. On the other hand, if the door's primary impact was to the client's hip, it should have caused at least some redness or bruising. However, three medical professionals examined the client and found no such evidence.[15] Therefore, the Investigative Summary's conclusion regarding how the injuries were sustained is highly speculative and must be given little evidentiary weight.

The client's memory was an issue in this case. She is 84 years old and has Alzheimer's Disease. According to the agency's psychologist, the client's case is unusual and she has been difficult to diagnose. The client may or may not have dementia and she has had delusions in the past. Testing of the client's cognitive abilities has shown an inconsistent pattern over time. On one hand, the client has not demonstrated a propensity for fabricating stories. On the other hand she has some short-term memory loss although it is not considered acute. At the hearing, the client testified that the door hit her and caused her fall. However, the client did not know who opened the door. She was also unable to remember other details such as which employee came into the tub room, whether she was dressed or undressed, or that the grievant had helped her up after the fall. Moreover, during her testimony, she did not recognize the grievant even though grievant was sitting to her immediate left. While the client now believes that the door hit her, her memory of the event is sufficiently hazy that relatively little evidentiary weight can be given to her testimony.

The agency concluded that grievant had not been truthful when she stated that she had been attending a second client in the tub room.[16] Grievant contends that she wheeled the second patient (who was in a geriatric chair) outside the tub room to an alcove area after the incident. The agency points to a patient monitor sheet as evidence that the second client was asleep in her bedroom at 7:00 p.m.[17] Agency policy requires that each client's whereabouts be recorded at 15-minute intervals based on actual observation by the person making the entry.[18] However, the certified nurse assistant (CNA) who made entries on the monitor sheet from 5:00 p.m. through 8:30 p.m. admitted that the entries prior to 8:00 p.m. were all made retroactively. The CNA claims that the registered nurse noticed at about 8:00 p.m. that the form had not been filled in for three hours and directed the CNA to "catch it up." The registered nurse, whose testimony was

---

[15] A registered nurse gave the client a head-to-toe assessment immediately after the fall, a physician examined the client two hours later, another physician examined her the following day, and a radiological examination was negative.

[16] The second client has severe cognitive impairment and was unresponsive to questioning by the investigator.

[17] Exhibit 1, p.29. Patient Monitor Sheet, March 5, 2003.

[18] Exhibit 4. *Patient Monitor Sheet Guidelines*, item 5: "The monitoring sheet is to be completed every 15 minutes on all patients, every shift, without exception." Item 7. " Indicating that a patient is present on the 15-minute check validates that the staff monitor has: **A. physically assessed the patients' presence, B. identified the patient by his face."** (Emphasis added)

credible, denies directing the CNA to "catch up" the Monitor Sheet. Thus, the whereabouts of 17 clients were recorded based solely on the CNA's memory of where she thinks each client may have been at each 15-minute interval.

The CNA's testimony overall was suspect for five additional reasons. First, the registered nurse did not corroborate her statement that the nurse directed her to "catch up" the patient monitor sheet. Second, the CNA contends that it was she who found the client sitting alone and crying in the tub room. Again, the registered nurse did not corroborate this assertion; the nurse said that the client was the only person in the tub room when she and grievant entered. Third, the CNA claimed to have written a witness statement on March 5, 2003 and given it to a supervisor. However, the agency was unaware of such a witness statement and it is not included in the investigation package.[19] Fourth, the CNA's whereabouts immediately prior to this incident were not fully explained. She claims that grievant sent her to obtain washcloths but grievant denies asking her to do so.[20] Finally, the CNA appeared somewhat ill at ease and uncertain during her testimony. While it is not uncommon for witnesses in a grievance hearing to be ill at ease because it is a new experience, the CNA's overall demeanor appeared to be more than just first-time jitters.

Both the first and second clients are designated as "fall risks." The normal practice is to have only one "fall risk" client at a time in the tub room. The agency contends that grievant's assertion that both clients were in the tub room at the same time must be false since this is not the normal practice. However, while this may be the normal and prudent practice, the agency acknowledges that there is no published or even verbal rule or policy that prohibits having two clients in the room together. Grievant avers that she had been tending to the second client in the geriatric chair when the first client walked into the tub room by herself. It would not have been unreasonable for grievant to allow an ambulatory client to stay once she had entered the room, especially since the second patient was in a geriatric chair and presented no immediate risk of falling.

In assessing the differing versions of one aspect of the incident, the investigator appears to conclude that grievant's version was the false version, but he fails to explain the basis for drawing his conclusion. For example, he states that "Ms [grievant] omitted, in her interview or written statement, that she ever spoke with Ms [CNA] while in the tub area just after the fall occurred." The investigator infers that the grievant deliberately omitted a fact from her statement. In fact, there is no evidence to prove whether grievant did or did not speak with the CNA. Since there is no corroborative evidence for either version, this

[19] The CNA's witness statement in the investigation package was written on March 10, 2003, not March 5, 2003.

[20] Since the client never identified who opened the door, it is conceivable that it was the CNA who opened the door, causing the client to reel backward and lose her balance, and then quickly left the scene to avoid culpability. Such a scenario would dovetail with both the client's version and grievant's version of what occurred.

observation must be assigned no evidentiary weight. However, the investigative report's characterization of the disputed fact is slanted against the grievant.

Summary

The evidence in this case is such that one could reasonably believe either that the client slipped and fell, or that she was knocked backward by an opening door. If she slipped and fell, as grievant avers, then grievant did not commit any offense that would be subject to discipline. If she was knocked off balance by an opening door, the agency has not proven, by a preponderance of evidence, that it was grievant who opened the door. Although the agency's version is possible, it has not demonstrated that its version is more likely to have occurred than grievant's version. The agency's evidence is underwhelming. It's rationale hinges primarily upon the hazy memory of an elderly client, and the falsified patient monitor sheet of an employee whose testimony was inconsistent and suspect. This evidence is simply insufficient to constitute a preponderance.

DECISION

The disciplinary action of the agency is reversed.

The Group III Written Notice and the removal of grievant from state employment on June 3, 2003 are hereby RESCINDED. Grievant is reinstated to her position with full back pay, benefits and seniority.

APPEAL RIGHTS

You may file an administrative review request within 10 calendar days from the date the decision was issued, if any of the following apply:

1. If you have new evidence that could not have been discovered before the hearing, or if you believe the decision contains an incorrect legal conclusion, you may request the hearing officer either to reopen the hearing or to reconsider the decision.

2. 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.

3. If you believe that the hearing decision does not comply with the grievance procedure, you may request the Director of EDR to

review the decision. You must state the specific portion of the grievance procedure with which you believe the decision does not comply.

You may request more than one type of review. Your request must be in writing and must be received by the reviewer within 10 calendar days of the date the decision was issued. You must give a copy of your appeal to the other party. The hearing officer's decision becomes final when the 10-calendar day period has expired, or when administrative requests for review have been decided.

You may request a judicial review if you believe the decision is contradictory to law.[21] 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.[22]

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

_____
David J. Latham, Esq.
Hearing Officer

[21] An appeal to circuit court may be made only on the basis that the decision was contradictory to law, and must identify the specific constitutional provision, statute, regulation or judicial decision that the hearing decision purportedly contradicts. *Virginia Department of State Police v. Barton*, 39 Va. App. 439, 573 S.E.2d 319 (2002). See also *Virginia Department of Agriculture and Consumer Services v. Tatum*, 2003 Va. App LEXIS 356, which holds that Va. Code § 2.2-3004(B) grants a hearing officer the express power to decide de novo whether to mitigate a disciplinary action and to order reinstatement.

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