Issue: Group III Written Notice with termination (client neglect); Hearing Date: 08/31/04; Decision Issued: 09/22/04; Agency: DMHMRSAS; AHO: Carl Wilson Schmidt, Esq.; Case No. 819

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case Number: 819

Hearing Date: August 31, 2004
Decision Issued: September 22, 2004

PROCEDURAL HISTORY

On June 21, 2004, Grievant was issued a Group III Written Notice of disciplinary action with removal for:

> *Termination for violation of Departmental Instruction 201, Reporting and Investigating Abuse and Neglect of Individuals Residing in Departmental Facilities.*

On August 29, 2004, Grievant timely filed a grievance to challenge the Agency's action. The outcome of the Third Resolution Step was not satisfactory to the Grievant and she requested a hearing. On July 27, 2004, the Department of Employment Dispute Resolution assigned this appeal to the Hearing Officer. On August 31, 2004, a hearing was held at the Agency's regional office.

APPEARANCES

Grievant
Grievant's Counsel
Agency Party Designee
Agency Advocate

Witnesses

ISSUE

Whether Grievant should receive a Group III Written Notice of disciplinary action with removal for client neglect.

BURDEN OF PROOF

The burden of proof is on the Agency to show by a preponderance of the evidence that its disciplinary action against the Grievant was warranted and appropriate under the circumstances. Grievance Procedure Manual ("GPM") § 5.8. 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 the evidence presented and observing the demeanor of each witness, the Hearing Officer makes the following findings of fact:

The Department of Mental Health Mental Retardation and Substance Abuse Services employed Grievant as a Registered Nurse until her removal effective June 21, 2004. The purpose of Grievant's position was:

> To ensure the clients are receiving optimal health care within the guidelines and policies of [the Facility]. Provide clinical supervision of nurses and render direct care to clients as needed.[1]

Grievant was the Registered Nurse Coordinator in her work area. She was responsible for assigning tasks to LPNs during the day.

The Client resides in one of the housing cottages at the Agency's Facility. He requires medical supervision and treatment as needed. The Client is ambulatory and does not normally use a wheelchair.

On May 5, 2004, Grievant worked the day shift which began at 6:42 a.m. and ended at 3:30 p.m. Grievant supervised the LPN. At approximately 8:00 a.m. the LPN observed and assessed the Client. She made an entry in the Client's Interdisciplinary Notes stating:

[1] Agency Exhibit 4.

> Client's right ankle is swollen, [small amount] of blood drainage from wounds noted. Client limping and appears to have some discomfort when ambulating.

Shortly thereafter, the LPN called Grievant and informed Grievant that the Client's ankle was swollen. Grievant called the Doctor[2] at the hospital and told the Doctor what the LPN stated about the Client's leg. The Doctor told Grievant that the Doctor was not coming to the housing unit until after lunch. Grievant called the LPN and informed her of the Doctor's comments. The LPN emphasized that the Client needed to be seen by the Doctor sooner. Grievant called the Doctor and said the Client needed to be seen sooner. The Doctor decided that the Client should be taken to the hospital for an x-ray.

Grievant was responsible for deciding how the Client would be transported to the hospital. It was up to Grievant to determine whether the Client needed to be moved by wheelchair and placed in a wheelchair capable van.

Grievant called the Van Driver and asked that the Van Driver pick up the Client and take him to the hospital. Grievant did not ask the Van Driver to bring a wheel accessible van.[3] Vans do not always have extra wheelchairs. If a client needs to use a wheelchair, that client must be placed in a wheelchair prior to boarding the van. The van then transports the client and his wheelchair to the appropriate destination.

The Van Driver went to the Client's cottage. Two aides assisted the Client in walking from the cottage to the van at the road.[4] They also helped the Client into the van. Once the Client reached the hospital, he walked from the van into the hospital.

Following the Client's x-ray, two staff brought him out from the hospital. One of the staff informed the Van Driver that the Client may have had a fracture. The Van Driver concluded that the Client needed to be in a wheelchair. She went to another building and obtained a wheelchair and then put the Client in the wheelchair. She put the Client into the van and transported him and the wheelchair to the Client's cottage.

Grievant did not make any entries into the Client's chart because she could not find it.

Grievant received prior disciplinary action. On September 12, 2003, Grievant received a Group II Written Notice for failure to perform assigned work according to established nursing standards.[5]

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[2] LPNs are not permitted to call physicians directly.

[3] Under the Agency's customary practice, the person calling for transportation is the one who must designate what type of transportation is needed. Grievant would have been responsible for deciding whether to ask for a wheelchair van.

[4] Grievant was working elsewhere when the Client walked to the van.

[5] Agency Exhibit 9.

CONCLUSIONS OF POLICY

The Agency has a duty to the public to provide its clients with a safe and secure environment. It has zero tolerance for acts of abuse or neglect and these acts are punished severely. Departmental Instruction ("DI") 201 defines client neglect as:

> 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.

DI 201 states, "It is expected that a facility director will terminate an employee(s) found to have abused or neglected a client."

Grievant failed to provide the care necessary to the health and safety of the Client. Upon being notified by the LPN that the Client had a swollen ankle, Grievant should have immediately gone to the Client and assessed the Client's needs.[6] If Grievant had properly assessed the Client,[7] she would have determined that the Client needed to be placed in a wheelchair as a precaution against further injury to his swollen leg.[8] The Client would not have had to walk with a fractured bone.

Grievant contends she assessed the Client after being informed by the LPN of the Client's swollen leg. The greater weight of the evidence does not support this conclusion. First, Grievant was responsible for documenting any assessment in the Client's chart if she had performed an assessment. The Client's chart did not show any record of an assessment by Grievant. Grievant contends she could not find the chart.[9] If Grievant could not find the chart, she was supposed to make a nursing note and then make sure those notes were transferred to the Client's chart at a later time.[10] Grievant did not make nursing notes. Second, if Grievant had assessed the Client, she would have known that the Client needed to be placed in a wheelchair as he was moved from

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[6] The Director of Nursing testified that Registered Nurses are taught not to call the doctor based on someone else's assessment of a patient.

[7] Grievant knew or should have known the important of performing and documenting assessments. She attended a nurses meeting on March 20, 2003 during which that topic was discussed. See Agency Exhibit 6.

[8] The Director of Nursing testified that by walking on a fractured limb, the Client could have additional damage to his leg bone or damage to the surrounding muscles and tissue.

[9] It is unclear why the LPN was able to make an entry into the Client's Interdisciplinary Notes at 8 a.m., but Grievant was unable to find the Client's Interdisciplinary Notes so that she could make her entry.

[10] The Facility is subject to Medicaid nursing home rules. Page 76 of chapter VI of the Medicaid Nursing Home Manual describes the industry standard as "Services not specifically documented in the recipient record as having been rendered shall be deemed not to have been rendered." Medicaid may deny reimbursement to providers failing to meet this documentation standard.

the cottage to the van. No evidence was presented from other cottage staff that Grievant had informed them the Client needed to be placed in a wheelchair in order to be moved from the cottage to the van. The Van Driver's testified credibly and with conviction that Grievant never informed her that the Client would require a wheelchair.

Grievant contends the Agency retaliated against her. No evidence was presented suggesting the Agency retaliated against Grievant.

DECISION

For the reasons stated herein, the Agency's issuance to the Grievant of a Group III Written Notice of disciplinary action with removal is **upheld**.

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. Please address your request to:

   Director
   Department of Human Resource Management
   101 North 14th St., 12th Floor
   Richmond, VA 23219

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. Please address your request to:

   Director
   Department of Employment Dispute Resolution
   830 East Main St. STE 400
   Richmond, VA 23219

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. 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.[11]

[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].

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Carl Wilson Schmidt, Esq.
Hearing Officer

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