Issue: Group III Written Notice with suspension (patient neglect); Hearing Date: 06/30/06; Decision Issued: 07/06/06; Agency: DMHMRSAS; AHO: David J. Latham, Esq.; Case No. 8372; Outcome: Agency upheld in full.

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 8372

Hearing Date: June 30, 2006
Decision Issued: July 6, 2006

APPEARANCES

Grievant
Attorney for Grievant
Two witnesses for Grievant
Representative for Agency
Two witnesses for Agency

ISSUES

Did 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 patient.[1] As part of the disciplinary action, grievant was suspended

[1] Agency Exhibit 3. Group III Written Notice, issued March 22, 2006.

for two days. Following failure of the parties to resolve the grievance at the third resolution step, the agency head qualified the grievance for hearing.[2] The Department of Mental Health, Mental Retardation and Substance Abuse Services (hereinafter referred to as "agency") employed grievant for 17 years as a human services direct support worker.

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] The policy requires all employees (including contract employees) to immediately report allegations of abuse or neglect of residents to the facility director.

A facility instruction policy requires that staff must maintain constant vigilance in their supervision of residents in order to assure their safety and accountability. The policy also requires that staff immediately take specific actions upon noticing that a resident is missing, including notification of the switchboard operator, and remaining at their work location until receiving further instructions.[4]

Grievant and a coworker were assigned to work in a living unit with ten residents. The doors on resident units have automatic door closers that shut the door after being opened. When the door is opened a loud bell sounds to alert staff that someone has either entered or left the unit. The bell alarm is sufficiently loud to be heard throughout the living unit even when there are loud voices. When the door closes fully, the door bell resets so that the bell can sound when the door is again opened. Grievant was aware that, for several months, the door sometimes did not fully close on its own.[5] When this happened, the door bell would not reset and it was then possible for someone to leave or enter without the bell sounding.

At about 1:40 p.m. on February 18, 2006, grievant hollered to her coworker that she was leaving the unit to go to a unit across the street to retrieve a soft drink she had left there the previous day. When grievant was preparing to leave the unit, a resident was standing near the door. This resident has a habit of standing near the door and when someone exits, he often sticks out his hand to prevent the door from fully closing. When grievant exited the unit, she did not look back to make sure the door was fully closed. Resident L had also been

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[2] Agency Exhibit 2. *Grievance Form A*, filed April 20, 2006.

[3] Agency Exhibit 9. Section 201-3, Departmental Instruction (DI) 201(RTS)00, *Reporting and Investigating Abuse and Neglect of Clients*, October 31, 2003. 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] Agency Exhibit 8. Facility Instruction 3, *Missing Residents*, April 27, 2004.

[5] Agency Exhibit 5. Investigator's Summary, attachment C.1.1, Investigator's Notes, and, attachment C.1.2, Grievant's written statement, February 21, 2006.

standing near the door when grievant left. Resident L has a tendency to wander away at times. Resident L is a 79-year-old, mentally ill male with behaviors that include delusional thinking, apparent hallucinations, and leaving the area without permission. He has no personal safety awareness. His Behavior Treatment Plan specifies that "L does need to be checked frequently or kept in sight because of his propensity to walk away from the area."[6]

During grievant's absence from the unit, her coworker received a telephone call from an employee in another unit who asked if a resident was missing because a resident without a coat had been spotted walking near the gymnasium. Grievant's coworker searched the unit and determined that resident L was missing. The temperature at this time was about 28 degrees with a wind chill of about 15 degrees.[7] Grievant returned to the unit about seven to ten minutes after she left and learned from her coworker that resident L was missing. Grievant left the unit and walked to the gymnasium to search for resident L. She searched in and around the gymnasium but was unable to find the resident, and then returned to the living unit.

By this time, resident L had walked past the gymnasium and out to the main entrance of the facility campus. The parents of a resident whom they had been visiting spotted resident L and took him to the living unit they had just been visiting. They reported that resident L "looked froze due to shivering and red skin."[8] Staff there then escorted resident L back to his assigned living unit. It was estimated that resident L was gone from his unit for about 22 - 24 minutes. Neither grievant nor her coworker ever called the switchboard operator.

A maintenance worker subsequently adjusted the door closer to assure that the door closed properly. He verified that the door bell alarm itself was functioning properly if the door was fully closed.

In 2005, grievant was counseled in writing that she must clearly coordinate with co-workers before leaving the residents assigned to her and must return in a timely manner.[9]

Grievant was disciplined with a Group III Written Notice and two days suspension for neglecting to assure that the door was properly closed, and for failing to immediately notify the switchboard operator when she learned the resident was missing. Also as a result of this incident, grievant's coworker was disciplined with a Group II Written Notice for failure to comply with the

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[6] Agency Exhibit 5. Investigator's Summary, attachment D.1.4, *Behavior Treatment Plan* for resident L., September 1, 2004.

[7] Agency Exhibit 5. Investigator's Summary, attachment D.1.8, Weather records for February 18, 2006.

[8] Agency Exhibit 5. Investigator's Summary, telephonic interview with parents who found resident L.

[9] Agency Exhibit 10. Notice of Improvement Needed, April 20, 2005.

established written policy requiring immediate notification of the switchboard operator when a resident is missing.

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:

> 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. In all other actions the grievant must present her evidence first and prove her claim by a preponderance of the evidence.[10]

To establish procedures on Standards of Conduct and Performance for employees of the Commonwealth of Virginia and pursuant to Va. Code § 2.2-1201, the Department of Human Resource Management (DHRM) promulgated *Standards of Conduct* Policy No. 1.60 effective September 16, 1993. The *Standards* provide a set of rules governing the professional and personal conduct and acceptable standards for 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 Policy No. 1.60 provides that Group III offenses include acts and

[10] § 5.8, Department of Employment Dispute Resolution (EDR) *Grievance Procedure Manual*, effective August 30, 2004.

behavior of such a serious nature that a first occurrence normally should warrant removal from employment.[11] It is expected that a facility director will terminate the employment of an employee who has abused or neglected a client.[12]

The agency cited grievant for neglect for multiple reasons. First, when grievant left the living unit, she did not assure that her coworker was observing resident L frequently or keeping him in line of sight. Second, she did not fully coordinate her trip away from the unit with her coworker. Although she notified him that she was leaving, she did not say for how long she would be gone. Finally, and most importantly, grievant did not assure that the door was fully closed when she left. Grievant knew that the door did not always fully close because it had been a problem since at least November 2005. In addition, grievant knew that another resident was in the habit of standing near the door and that he would sometimes put out his hand to prevent the door from fully closing. Given this knowledge, grievant had a duty to take extra precautions to assure that the door was fully closed so that the alarm would reset. Grievant admitted that she failed to check the door after she left. Instead, she thought she heard the door slam and relied on that noise as being sufficient to indicate that the door was fully closed. Grievant did not turn around to look at the door, and did not push the door fully closed. At a minimum, grievant could have taken these precautions to assure that the door was fully closed. Under the circumstances, and given her knowledge that the door had not been closing fully, her failure to take such precautions was neglectful.

Although grievant contends the door slammed when she left, the coworker did not hear the alarm sound when resident L left the unit. Even though the coworker may have been contending with two squabbling residents at the time resident L left, he would have heard the alarm if it had sounded. The fact that the alarm did not sound strongly suggests that the door was not fully closed when resident L exited the unit.

The agency also cited grievant for failure to comply with written established policy because she did not follow the search procedures in the Missing Residents policy. Specifically, grievant did not notify the switchboard operator and, did not remain in her assigned living area until receiving further instructions. Grievant argues that she did not notify the switchboard because she did not consider the resident to be “missing” since she had had been told he was in the area near the gymnasium. This argument is not persuasive. The fact is that there had been only an unverified report that an unknown person had been seen walking in the vicinity of the gymnasium. There was no confirmation either that this person was resident L or that he was at the gymnasium. When grievant went to the gymnasium, resident L was not in or near the gymnasium. Until grievant (or another employee) could actually see resident L, he was in fact missing because no one knew for certain where he was. When grievant was unable to find resident L at the gymnasium, she states that she called her

[11] Agency Exhibit 4. Facility Instruction 106, *Standards of Conduct*, January 13, 2004.
[12] Agency Exhibit 9. Section 201-9, DI 201(RTS)00, *Id*.

coworker and told him to call Security. However, this does not absolve grievant of her own responsibility to call the switchboard operator. According to policy, grievant should have called the switchboard operator when she first learned of the missing resident and, she should not have left the unit; she should have remained there until receiving further instructions.

Mitigation

The normal disciplinary action for a Group III offense is removal from employment. The policy provides for the reduction of discipline if there are mitigating circumstances such as (1) conditions that would compel a reduction in the disciplinary action to promote the interests of fairness and objectivity; or (2) an employee's long service or otherwise satisfactory work performance. In this case, grievant has been employed for 17 years and has otherwise satisfactory performance. However, less than one year earlier, grievant had received a Notice of Improvement Needed for her failure to properly coordinate with coworkers before leaving the work site. Nonetheless, because of grievant's long service and the fact that grievant did not intentionally neglect the resident, the facility director requested and received permission to reduce the discipline from termination of employment to a two-day suspension.[13] Based on the totality of the evidence, the hearing officer concludes that the agency properly applied the mitigation provision.

DECISION

The disciplinary action of the agency is affirmed.

The Group III Written Notice and two-day suspension of grievant is hereby UPHELD.

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 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. Address your request to:

[13] Agency exhibit 6. E-mail from facility director to assistant commissioner, March 14, 2006.

Director
Department of Human Resource Management
101 N 14th St, 12th floor
Richmond, VA 23219

3. If you believe 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. Address your request to:

Director
Department of Employment Dispute Resolution
830 E Main St, Suite 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 15 calendar days of the date the decision was issued. You must give one copy of any appeal to the other party and one copy to the Director of the Department of Employment Dispute Resolution. The hearing officer's **decision becomes final** when the 15-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.[14] 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.[15] You must give a copy of your notice of appeal to the Director of the Department of Employment Dispute Resolution.

[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]

S/David J. Latham

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David J. Latham, Esq.
Hearing Officer

[14] 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).

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