Issue: Group III Written Notice with termination (client neglect); Hearing Date: 08/26/10; Decision Issued: 09/13/10; Agency: DBHDS; AHO: Carl Wilson Schmidt, Esq.; Case No. 9384; Outcome: No Relief – Agency Upheld; **Administrative Review: AHO Reconsideration Request received 09/24/10; Outcome pending.**

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case Number: 9384

Hearing Date: August 26, 2010
Decision Issued: September 13, 2010

PROCEDURAL HISTORY

On May 25, 2010, Grievant was issued a Group III Written Notice of disciplinary action with removal for client neglect.

On June 1, 2010, 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 August 2, 2010, the Department of Employment Dispute Resolution assigned this appeal to the Hearing Officer. On August 26, 2010, a hearing was held at the Agency's office.

APPEARANCES

Grievant
Grievant's Counsel
Agency Representative
Witnesses

ISSUES

1. Whether Grievant engaged in the behavior described in the Written Notice?

2. Whether the behavior constituted misconduct?

3. Whether the Agency's discipline was consistent with law (e.g., free of unlawful discrimination) and policy (e.g., properly characterized as a Group I, II, or III offense)?

4. Whether there were mitigating circumstances justifying a reduction or removal of the disciplinary action, and if so, whether aggravating circumstances existed that would overcome the mitigating circumstances?

BURDEN OF PROOF

The burden of proof is on the Agency to show by a preponderance of the evidence that its disciplinary action against 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 Behavioral Health and Developmental Services employed Grievant as a Direct Service Associate II at one of its Facilities. Grievant had been employed by the Agency for approximately 21 years prior to her removal effective May 25, 2010. No evidence of prior active disciplinary action against Grievant was introduced during the hearing. With the exception of the facts giving rise to this disciplinary action, Grievant's work performance was satisfactory to the Agency.

The Individual is a 66 year old male with profound physical disabilities. He uses an anti-tip wheelchair that is difficult to tip over if it is on a level surface. The wheelchair is designed with a low center of gravity and has built-in shock absorbers to reduce the effect of pushing one's weight against the chair. The frame is sturdy and weighs more than the typical wheelchair. The wheelchair has a seat belt which is kept fastened when the Individual is in the wheelchair. It is designed for a person with severe uncontrolled movements.

On March 22, 2010, Grievant was assigned responsibility to provide care to the Individual and another person residing in the Building. Although the Individual was supposed to have been "shadowed" and the sole responsibility of Grievant, Grievant was not advised of her obligation to focus on the Individual.

In the evening of March 22, 2010 at approximately 8 p.m., the Registered Nurse propped open a door in one of the Buildings in which individuals receiving services from the Agency lived. The Individual observed the open door and rolled his chair through

the door and ultimately outside of the Building. He rolled his wheelchair down the left hand ramp. The Building sits on a steep hill with grass on it and a road at the base of the hill. The Individual rolled his wheelchair onto the hill. Due to gravity and the pitch of the hill, the Individual's wheelchair rolled down the hill and was out of the Individual's control. The wheelchair tipped over onto its left side. It stopped midway down the grass hill. The Individual was strapped inside the wheelchair and unable to extricate himself. A few minutes later, five citizens were in a vehicle driving by the Building. They observed the Individual whose legs were shaking and he appeared to be in shock. They exited their vehicle and approached the Individual. They were hesitant and careful not to touch the Individual. One of the citizens, Mr. A, walked up the hill and encountered Ms. M, a DSA II. He told her what he had observed and led her down the hill to where the Individual was laying. Two other citizens, Mr. B and Mr. CA, entered the Building and met Grievant and Ms. C and said that there was a man outside lying on the side of a hill in a wheelchair. Grievant and the two citizens left the Building and walked to where the Individual was on the hill. Ms. M arrived at the Individual's location at the same time Grievant got there. Ms. C walked into the laundry room and told Ms. RN that the Individual was found outside and may need help. The Med Aide locked her cart, left the Building, and walked to where the Individual was located. Ms. RN and Ms. C left the Building and walked down the hill to join the others where the Individual was located.

Ms. RN and Ms. M attempted to upright the Individual's wheelchair with the Individual still strapped in but their attempt failed. Grievant and the Med Aide were standing above the Individual. Ms. C remained standing near the entrance of the Building.

Grievant held the wheelchair as Ms. RN and Ms. M unhooked the Individual's seat belt. The Individual rolled out of the wheelchair onto the ground without support.

Ms. M grabbed the Individual under his arms and shoulders from behind. Ms. RN grabbed the Individual's legs underneath his knees. They carried the Individual up the hill. Ms. M did not provide proper support for the Individual's neck and head. The citizens who observed the Individual being carried became upset with how the individual was being carried because they feared staff were further injuring the Individual. Grievant stood close to the Individual as he was being carried but did not assist with the carrying. The Med Aide moved the wheelchair to the sidewalk behind the Building, and up the sidewalk to the top of the hill behind the Building.

Ms. RN and Ms. M placed the Individual in the wheelchair. Ms. M watched staff as they pushed the Individual in his wheelchair back to the day hall inside the Building. Ms. M did not report the incident to her supervisor or notify anyone that the incident occurred.

At approximately 8:23 p.m., the Charge Aide heard a commotion in the day hall. The Charge Aide had been taking her lunch break and was in the break room talking on her cell phone. She was unaware of what had happened. She entered the day hall and

asked staff what had happened to the Individual. The Charge Aide was falsely informed that the Individual had fallen just outside of the entrance to the Building. The Charge Aide was informed by staff that they did not wish to report the incident. The Individual appeared to the Charge Aide to be cold and frightened.

At 8:26 p.m., the LPN was paged to go to the Building to see the Individual. At 8:40 p.m., the LPN arrived at the Building and conducted an assessment of the Individual. The Individual was alert and guarding his left knee. Both of the Individual's knees were reddened. He had an abrasion on his right heel. His right upper chest was reddened. At 9 p.m., the Individual was transported by emergency vehicle to the Facility's Medical Clinic.

On March 25, 2010 at 1:25 p.m. a message was left at the Facility Director's office by one of the citizens asking the status of the Individual. The Agency began an investigation.

Grievant wrote on March 22, 2010 in her first statement[1]:

> I was on the day hall with individuals and assisted with another individual when I turned around and saw the top of an individual's head going through the doors. I yelled for assistance. I ran after him and he was going fast in the wheelchair, I yelled his name and he kept going through the automatic door onto which was opened, and turned the wheelchair over on the sidewalk. Two staff assisted with him after he turned over. [Ms. C] assisted me. I was working on overtime and was not familiar with the individual; but I am a good learner and willing to work and learn.

Ms. RN wrote on March 22, 2010 in her first statement:

> I was cleaning up the shower room for the night after bathing. Then I went to the laundry room to get a load of clothes in the washer. Then staff asked for help so I came out to assist.

Ms. C wrote on March 22, 2010 in her first statement:

> I was assisting the med-aid with an individual when I heard [Grievant] call for help. When I got to the porch the individual was laying on his side still seat belted in his chair. [Grievant] assisted him up and back inside.

The Shift Supervisor wrote in his statement:

> I got to [the Building] at 8:30 p.m. My pager had just went off from [the Building]. I was told that [the Individual] was seen rolling himself out the door leading from the day hall to the front of the building. Staff (as I was

[1] Grievant wrote a similar statement in the Individual's Inter-disciplinary Notes.

told) went after [the Individual] but could not get him before he got outside and rolled down the steps. The staff assigned to that home were: [Ms. C, Grievant, Ms. RN, and the Charge Aide]. This is what I was told by each staff person where they were at during the time of the incident. [Ms. C] was helping the Med Aide in another room. [Grievant] was on the living area assisting an individual. She was the group leader that had [the Individual]. She was the one that saw him rolling towards the door. [Ms. RN] was in the laundry room. [The Charge Aide] was on dinner break.

The Registered Nurse wrote in her statement:

I was paged to come see [the Individual] because he had fell down the steps, but later I found out that was a misunderstanding, he actually had fell over in the wheelchair on his right side. When I got to the scene, [the Individual] was alert, guarding his left knee, we were in the bathroom checking him over and the [emergency vehicle] was called. He was shaking so I got the med-Aide to give him [medicine] which she did. Both knees were reddened, right heel abrasion, right upper chest reddened area. There were no areas on his back or buttocks. This was a quick assessment when the [emergency vehicle] arrived. [The Individual] fell over in the wheelchair going outside, and that's why the [emergency vehicle] was called. He has osteoporosis and could have broken a bone. He also had a reddened area to the right side of his face.

Ms. RN wrote on March 29, 2010 in her second statement:

I am truly sorry for lying to the investigator. If I had it all over again I would tell the truth. Truly, I am sorry. I had to clean up the shower room after bathing the guys. I went to the laundry room to put clothes in the washer and take a load out of the washer. [Ms. C] came to the door of the laundry [room] and yelled for help. That’s when I came out to assist with the client. The client was mid ways on the grass. I went down to assist with him. I took both of his legs and [Ms. M] got his back and began to take him up the hill. I took him back up and put him in the chair. I was scared so that is why I said what I said. [The Police Officer] told us “to cover our own ass.” [The Med Aide] brought the chair back up the hill after I got through assisting with the client. I went back to doing my chores. I had some bibs in my hand at the time of the incident.

Grievant wrote on March 30, 2010 in her second statement:

I was on the day hall looking through my flow sheet book to sign when a man arrived on the day hall and stated that a patient was on top of the hill and that he had turned his wheel chair over! I looked around and I said to myself … who was it? And someone said I bet it was [the Individual]. I said to myself he’s my individual[.] [M]yself, [Ms. M], [the Med Aide] and

[Ms. RN] went to assist. I was too shaken to do the Lifts so I asked them would they lift him up. So [Ms. M] and [Ms. RN] did the lift, placed him in the wheelchair, and we returned back to the day hall to check the individual for injuries. We called the supervisor and nurse. [The Police Officer] arrived to take pictures and he made a statement to cover your own asses (with our own statements). I would not abuse and neglect anyone. I am terrified and sorry for the incident that happened. I am still shaken about the incident.

I was assigned to work [at the Building] OT; when I arrived on the living area, I stated to staff that I didn't know [the individuals] that well. I was assigned to [the Individual] and [another individual] from [another facility]. The acting charge [Aide] didn't inform me of the behavior plan, PNMP, and shadowing which supposedly was supposed to be taken over every two hours. Nobody said anything to the incident that happened and all the automatic doors were open when the individual went outside. I take my job with pride.

Grievant and other staff at the Facility receive training on an annual basis to remind them that if an individual falls down to the ground the way the Individual did on March 22, 2010, the appropriate action is not to touch the individual but rather to call for emergency medical service. The Facility has its own emergency response service.

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 authorized removal for neglect.

Va. Code § 37.2-100 defines neglect as:

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.

Grievant is not responsible for the Individual getting out of the Building without supervision. A door was left open by another employee. Grievant would not have been expected to anticipate that happening. Grievant did not observe the Individual leaving the Building.

Grievant had been trained that when she observed an individual who had fallen to the ground, she was supposed to call the emergency medical services to respond to the individual. She had been trained to refrain from moving an individual who had

fallen. When Grievant first observed the Individual on the grass, she disregarded her training. She failed to return to the Building and call for an EMT, nurse, or doctor to come to assess the Individual. By failing to call for emergency medical service, Grievant denied the Individual a medical assessment that could have determined whether it was safe to move the Individual and how the Individual should have been moved. Because Grievant panicked instead of following her training, she denied necessary services for a person receiving care at the Facility. Grievant engaged in client neglect.

When the Individual was returned to the Building, the Charge Aide asked what had happened. The Individual's medical circumstances may have changed by that point in time. He could have been further injured by being moved up the hill. Grievant could have taken that opportunity to reveal that the Individual had rolled down the hill and fallen and that the Individual had been moved back up the hill. Doing so would have enabled the Charge Aide to call for assistance and properly inform the responders of the Individual's circumstances. As a result of Grievant's failure to accurately state the facts of the incident, the Charge Aide, Registered Nurse, and Shift Supervisor were making decisions regarding the Individual's medical treatment based on false assumptions. They were assuming that the injuries caused to the Individual were from an offense less serious than the actual event. Grievant knew the truth and was in a position to reveal the truth but failed to do so. Her failure to do so constituted client neglect.

The Agency has presented sufficient evidence to support the issuance of a Group III Written Notice for client neglect. Upon the issuance of a Group III Written Notice, an agency may remove an employee. Accordingly, Grievant's removal must be upheld.

Grievant argued that she panicked and would never do anything to intentionally neglect an individual under her care. Although it is clear that Grievant enjoyed her job and was devoted to helping individuals at the Facility, it is not necessary for the Agency to show that Grievant's actions were intentional. Client neglect can be established by showing that an employee made mistakes even if the employee's objective was to assess an individual.

Va. Code § 2.2-3005.1 authorizes Hearing Officers to order appropriate remedies including "mitigation or reduction of the agency disciplinary action." Mitigation must be "in accordance with rules established by the Department of Employment Dispute Resolution…."[2] Under the *Rules for Conducting Grievance Hearings,* "[a] hearing officer must give deference to the agency's consideration and assessment of any mitigating and aggravating circumstances. Thus, a hearing officer may mitigate the agency's discipline only if, under the record evidence, the agency's discipline exceeds the limits of reasonableness. If the hearing officer mitigates the agency's discipline, the hearing officer shall state in the hearing decision the basis for mitigation." A non-

[2] Va. Code § 2.2-3005.

exclusive list of examples includes whether (1) the employee received adequate notice of the existence of the rule that the employee is accused of violating, (2) the agency has consistently applied disciplinary action among similarly situated employees, and (3) the disciplinary action was free of improper motive.

Grievant argued that the Agency inconsistently discipline the employees involved in the incident. The Agency concluded that five employees had engaged in client neglect. Those employees included: Grievant, Ms. SC, Ms. C, Ms. M, and the Med Aide. Ms. M and the Med Aide were not removed from employment. They received a Group III Written Notice and a 10 work day suspension. The two employees who were not terminated were not similarly situated with Grievant. For example, the Med Aide was truthful in her statements regarding what occurred. In her statement to the Investigator, she indicated that the Individual was found down the hill laying on his side. Ms. M also told the Investigator that she observed the Individual turned over on the hill.

Grievant argued that her first statement was false because the Police Officer told her to "cover her ass". Although the Police Officer's choice of words is troubling, Grievant's decision to cover up the incident was made prior to any statements by the Police Officer. The Police Officer had not yet arrived when the Charge Aide first asked what had happened to the Individual. Grievant failed to express the actual circumstances that had occurred. In addition, when Grievant signed her first statement she certified that:

> I may not violate the confidentiality of this investigation or discuss the investigation with others during the course of the investigation. I understand that if my actions compromise the integrity or outcome of the investigation, I may be subject to the full range of disciplinary actions as outlined in the Commonwealth's Standard of Conduct Policy 1.60.

Moreover, Departmental Instruction 201 requires employees to "[p]rovide accurate and complete information during interviews with the Investigator or in an administrative proceeding".

In light of the standard set forth in the Rules, the Hearing Officer finds no mitigating circumstances exist to reduce the disciplinary action.

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 **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. 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
   600 East Main St. STE 301
   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 a copy of all of your appeals to the other party and to the EDR Director. 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. 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.[3]

[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].

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

S/Carl Wilson Schmidt

Carl Wilson Schmidt, Esq.
Hearing Officer