Issues: Management Actions (non-disciplinary transfer), Group III (failure to follow instructions/procedure, Group III (failure to follow instructions/procedure), and termination; Hearing Date: 09/26/16; Decision Issued: 03/03/17; Agency: DBHDS; AHO: Carl Wilson Schmidt, Esq.; Case No. 10856, 10863; Outcome Partial Relief; **Administrative Review: EEDR Ruling Request received 03/18/17; EEDR Ruling No. 2017-4525 issued 04/06/17; Outcome: AHO's decision affirmed.**

COMMONWEALTH of VIRGINIA

Department of Human Resource Management

OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In re:

Case Number: 10856 / 10863

Hearing Date: September 26, 2016
Decision Issued: March 3, 2017

PROCEDURAL HISTORY

On March 21, 2016, Grievant was transferred from the Facility where she worked to the Central Office. On June 22, 2016, Grievant was issued a Group III Written Notice of disciplinary action with removal for failure to implement a plan of correction thereby placing patients in immediate jeopardy. On June 22, 2016, Grievant was issued a second Group III Written Notice of disciplinary action with removal for failure to consistently develop, implement, and evaluate nursing standards.

On April 14, 2016, Grievant timely filed a grievance to challenge the Agency's transfer of Grievant from her position at the Facility to the Central Office. On July 20, 2016, Grievant filed a grievance to challenge the Agency's disciplinary actions. The matter proceeded to hearing. On August 4, 2016, the Office of Employment Dispute Resolution qualified in part and consolidated Grievant's grievances for hearing. On August 22, 2016, the Office of Employment Dispute Resolution assigned this appeal to the Hearing Officer. On September 26, 2016, a hearing was held at the Agency's office.

APPEARANCES

Grievant
Grievant's Counsel
Agency Party Designee
Agency's Counsel
Witnesses

ISSUES

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

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?

5. Whether the Agency inappropriately transferred Grievant to the Central Office and interfered with Grievant's rights under the FMLA?

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. Grievant has the burden of proof to show that her transfer was contrary to State policy. 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 Chief Nurse Executive[1] at one of its facilities. She began working in this position in August 2011. No evidence of prior active disciplinary action was introduced during the hearing.

The purpose of Grievant's position was:

> This position is directly responsible to the Hospital Director[2] for the provision of safe and competent Nursing Care; for accomplishing the

[1] Also referred to as Director of Nursing in this decision.

[2] Also referred to as the Facility Administrator in this decision.

goals and objectives of the Hospital and overseeing the Nursing Department.[3]

Grievant's Core Responsibilities included Management, Supervision, and Leadership of Nursing Services. She was to provide overall direction and leadership for the Department of Nursing. Grievant's Core Responsibilities included Develop, Implement, and Evaluate Nursing Standards. She was to develop and implement nursing standards of practice and standards of care consistent with professional and regulatory agency nursing standards. Her Employee Work Profile (EWP) required that she "[e]nsure effective nursing staff participation in treatment planning."[4] Grievant received a rating of Exceeds Contributor for her 2012 and 2013 annual performance evaluations.

On June 2, 2015, the Facility Administrator sent Facility staff an email stating, "I am appointing [Grievant] to oversee all nursing services at [the Facility].[5] Grievant was responsible for making sure regulatory nursing standards were met by the Facility.

Patients at the Facility were supposed to have individualized treatment plans. A treatment plan is multi-disciplinary action that includes nursing care that guides treatment for patients. Every patient treatment plan involves a nursing intervention. A nursing intervention is something nursing staff do as directed by the treatment plan to achieve the goals of the treatment plan.

The Facility is subject to on-site audits by regulatory agencies. These audits are called surveys.

The Centers for Medicare and Medicaid Services (CMS) sets the standards for hospital reimbursement. CMS provides Federal money to match State Medicaid expenditures. CMS provides Federal money as part of the Medicare program.

The Joint Commission is an accrediting body. The Joint Commission usually conducts surveys every three years on behalf of CMS. The Virginia Department of Health conducts field audits of facilities and applies CMS standards to determine if facilities should retain their licensure. The VDH field audits are often "complaint based".

The Facility received a Statement of Deficiencies following each survey. The Facility developed a Plan of Correction to address each deficiency and presented that plan to the auditors. Grievant was involved with the Facility Administrator in drafting the Plans of Corrections for nursing services.

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[3] Agency Exhibit J.

[4] Agency Exhibit J.

[5] Grievant Exhibit 3.

The Facility has "group rooms" where patients may receive services. Between two group rooms at the end of a hallway in the Building at the Facility are two restrooms. Each restroom has a door with a lock.

In September 2014, an intellectually disabled woman was allegedly sexually assaulted in the women's restroom located on the secure hallway at the Facility. The event was not observed by staff.

On October 10, 2014, the Facility Administrator sent Grievant and several other managers a memorandum regarding a case "unsubstantiated for neglect with regards to the alleged rape …." The Facility Administrator identified "administrative issues" as:

- The Woman's Bathroom was noted as having a work order placed for a counter. If work was to be done, the bathroom should have been placed "out of order" and not made available to clients to use.
- The staff monitoring the hallway should be placed on either side of the secure hallway to be able to see each other walking up the hallway and pass each other as they do checks. Bathroom supervision must be monitored closer after this situation.
- Group Facilitators need to be mindful of how many people they let use the bathroom along with allowing a female to go at the same time as a male.

Please discuss these administrative issues with appropriate staff and provide a plan of correction to my office by October 23, 2014. [6]

On October 17, 2014, the Facility Administrator sent the Investigations Manager a memorandum regarding the September 2014 allegation of abuse. Grievant was copied on the memorandum. The memorandum provided, in part:

Corrective Action Points:

- Staff to open bathroom door and stay outside the bathroom until patient leaves the bathroom.
- The locked bathrooms and the staff monitor at the bathroom door will be the resource that the group facilitator needs.[7]

On December 2, 2014, the Clinical Account Executive sent several nursing managers an email stating:

Staff must monitor the bathrooms in the secure hallway as well as be inside the area and NOT standing at the exit doors. This is a part of a Plan of Correction and must be adhered too.

[6] Agency Exhibit K.

[7] Agency Exhibit K.

- Bathroom will have mechanism installed that locks door when pulled shut from hallway but never locked from inside the bathroom. Staff will have key needed to unlock door.
- Staff to open bathroom door and stay outside the bathroom until patient leaves the bathroom.
- The locked bathrooms and the staff monitor at the bathroom door will be the resource that the group facilitator needs.[8]

Agency staff were positioned outside of the restroom while a patient was inside in order to prevent any other patient from entering the restroom. Staff were also positioned in the hallway. A staff member was positioned at the end of the hallway even when no patient was inside a restroom.

The Facility Administrator began working at the Facility in April 2015. Grievant reported to the Facility Administrator.

The Facility was subject to a survey on June 5, 2015.

The CMS sent the Facility Administrator a letter dated July 23, 2015 regarding a CMS survey of Joint Commission accredited hospitals participating in Medicare. The Agency was advised:

> If, in the course of such a survey, a hospital is found not to meet one of the Medicare Conditions of Participation, we are required to place the hospital under state survey agency jurisdiction until it is in compliance with all Medicare Conditions of Participation.
>
> Based on a report of the deficiencies found during the sample validation survey of your hospital on June 5, 2015 (health survey) and July 15, 2015 (fire safety survey), we found that [Facility] is not in compliance with the following Federal regulations:
>
> 42 CFR 482.21 Quality Assurance and Performance Improvement
> 42 CFR 482.45 Organ, Tissue, Eye Procurement
> 42 CFR 482.61 Special Medical Record Requirements for Psychiatric Hospitals
>
> The health deficiencies are serious and require immediate attention. Based on this survey, we are removing the deemed status of [Facility] and placing the hospital under state survey agency jurisdiction.
>
> The finding that the [Facility] is not in compliance with the above Conditions of Participation does not affect your hospital's JC accreditation,

[8] Grievant Exhibit 4.

its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. However, you are required to submit an acceptable plan of correction regarding these deficiencies. After the approved plan of correction has been implemented, and we have found that all of the Medicare Conditions of Participation for hospitals are met, we will discontinue the state's survey jurisdiction. ***

You are advised that failure to achieve compliance with the Conditions of Participation, in accordance with the time frames set forth in an acceptable plan of correction, will result in the initiation of action to terminate your facility from the Medicare program. The state survey agency may perform monitoring visits to determine your progress toward correcting the deficiencies. ***[9]

A Statement of Deficiencies provided, in part:

B 148

482.62(d)(1) NURSING SERVICES

The director must demonstrate competency to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

This STANDARD is not met as evidenced by:
Based on record review, document review, observation, patient interview and staff interview, the Director of Nursing failed to: (I) Develop individualized nursing interventions that addressed specific patient needs in eight (8) of eight (8) active sample patients …. (II) Ensure that registered nurses (RNs) document specific information about medication education assigned for eight (8) of eight (8) active sample patients … and (III) Ensure that on unit patients were provided alternative, individualized programming throughout weekdays, evenings and weekends for eight (8) of eight (8) active sample patients.

Grievant was involved in the Agency's development of a Plan of Correction to address the deficiencies. The Plan of Correction provided as follows:

TAG B 148 PLAN OF CORRECTION:
[The Facility] will ensure the Chief Nurse Executive demonstrate[s] competences to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

[9] Agency Exhibit K.

PROCEDURE/PROCESS FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION:
The Chief Nurse Executive will ensure all Nursing Staff are educated through policy or procedure on individualized nursing interventions that address specific patient needs, ensure that registered nurses (RNs) document specific information about medication education and ensure on unit patients are provided alternative and individualized programs on weekdays, evenings, and weekends.
MONITORING AND TRACKING:
The Registered Nurse Coordinator (RNC) will monitor and track nursing care and treatment plans to ensure they are kept current and updated. The RNC will provide feedback to nursing staff when warranted. Results of [this] will be provided to the Chief Nursing Executive (CNE) for review and analysis.
Each Unit RNC will audit medication education notes to ensure completion and hand-off communication. The audit will be forwarded to the Chief Nurse Executive for review and analysis.
In collaboration with the Rehab Case Managers, the Unit RNC's will review patient group participation and accompanying treatment plans, as needed. Rehab Supervisors will monthly perform clinical pertinence to review patient involvement in the Incentive Program and assess increase in scheduled programming.
PROCESS IMPROVEMENT:
The CNE will submit a monthly report of nursing care and treatment plan analysis to the Quality Council.
The Quality Council will review report and make recommendations for further corrective/preventive action as necessary. The Rehab Supervisor will compile group data to include groups provided, patient participation and contact hours monthly and report the findings to the Hospital Clinical Leadership. The Hospital Clinical Leadership will review findings and make recommendations as needed. The Clinical Director will report group data analyses and any actions to the Quality Council on a quarterly basis.
INDIVIDUAL RESPONSIBLE:
Chief Nurse Executive[10]

A second CMS survey of the Facility was conducted on October 14, 2015. The CMS sent the Facility Administrator a letter dated December 7, 2015 stating:

> After careful review of the facts, the Department of Health & Human Services has determined that [the Facility] no longer meets the requirements for participation as a provider of services in the Health Insurance Program for the Aged and Disabled (Medicare), established under Title XVIII of the Social Security Act. *** Please note, if you do not take corrective action as here indicated, and your agreement to participate

[10] Agency Exhibit M.

in the Medicare program is terminated, [the Facility] will not be readmitted to the program unless you can demonstrate to CMS that the reason for termination has been removed and there is a reasonable assurance that it will not appear.[11]

The CMS described a State of Deficiencies as:

B148

481.62(d)(1) NURSING SERVICES

The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

This STANDARD is not met as evidenced by:
Based on record review, document review, observation, patient interview and staff interview, the Director of Nursing failed to:

l. Develop individualized nursing interventions that addressed specific patient needs in nine (9) of nine (9) active sample patients ….

***

In an interview on 10/13/15 at 3:30 p.m., the Director of Nursing confirmed that intervention statements contained the identical or similarly worded [information]. She agreed that some interventions were nursing functions and that the statement regarding medication education did not include a modality (individual or group contacts). She also agreed that these [deficient] practices were noted during the June 1-3/15 CMS survey.[12]

Grievant was involved in the Agency's development of a Plan of Correction to address the deficiencies. In response to the CMS letter, the Director of Quality Management sent CMS a letter dated December 23, 2015 outlining a Plan of Correction to meet the CMS standards:

B 148

PLAN OF CORRECTION
Please see the plan of correction initiatives for B-Tag 122 which includes the following:

[11] Agency Exhibit P.

[12] Agency Exhibit P.

1. Appointment of a Care Coordinator for Units 3A/3B
   A. Implement a Plan-Do-Check-Act quality plan to evaluate treatment modalities.
2. Establish unified treatment team work sessions to ensure that all disciplines are writing the patients treatment plan together.
3. Conduct mandatory treatment plan training on Units 3A/3B for treatment team members to include goal development, objective development, active treatment interventions and modalities.
   A. Implement a Plan Do Check Act quality plan to monitor the quality and completion of the training.
4. Develop a "Treatment Plan at A Glance" knowledge sheet to assist staff with treatment plan development post mandatory training.
5. Treatment Teams on Units 3A/3B will dedicate a scribe during each treatment plan development meeting to ensure documentation consistency.
6. Adopt a new utilization review tool for utilization review to utilize during treatment plan audits.
7. The utilization review department will conduct a treatment plan chart review of all patients assigned to Units 3A/3B.
   A. Implement a Plan Do Check Act quality plan to ensure the quality of the chart review.
8. Complete 100% treatment plan review by utilization review for all new admissions to Units 3A/3B within (7) days.
   A. Implement a Plan Do Check Act quality plan to ensure the quality of the chart reviews.
9. Install visual/computer equipment in the treatment team conference rooms. to improve treatment plan development.
10. Install "Treatment Plan Key Steps" posters in the treatment team conference rooms … to assist in quality treatment plan development.[13]

The Facility Administrator met with Grievant and told her to monitor and ensure all nursing treatment plan interventions were current and up-to-date because he expected a CMS follow-up survey soon after submission of the plan of correction on January 22, 2016. The Facility Administrator told Grievant that the Facility could not fail to meet the standard a third time.

A third survey was conducted of the Facility on February 24, 2016. Medical records for nine of 39 patients were reviewed. The Statement of Deficiencies stated, in part:

482.61(c)(1)(iii) TREATMENT PLAN

The written plan must include the specific treatment modalities utilized.

[13] Agency Exhibit Q.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to identify in the MTP specific treatment interventions/modalities to address the identified patient problems for seven (7) of nine (9) active sample patients …. The treatment interventions were stated in vague terms, consisted of a long list of groups that did not relate to the short term goal or were non-individualized generic discipline functions rather than directed at specific interventions. In addition there were no nursing interventions documented for four (4) of nine (9) active sample patients …. This deficiency results in failure to guide treatment staff regarding the specific treatment purpose of each intervention to achieve measurable behavioral outcomes for patients.[14] ***

B 148
482.62(d)(1) NURSING SERVICES
The director must demonstrate competency to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

This STANDARD is not met as evidenced by:
Based on record review, observation and interview, the Director of Nursing failed to:
Ensure nursing interventions were documented on the MTPS for four (4) of nine (9) active sample patients …. This deficiency results in potential failure to provide patients with needed nursing care and fails to guide nursing staff in addressing individual patient care needs.[15]

Grievant's mother became hospitalized. Grievant requested leave under the Family Medical Leave Act to assist her mother. She submitted a form describing the period of incapacity beginning April 1, 2015 to April 1, 2016. She was approved for intermittent FMLA leave beginning May 27, 2015. In February 2016, Grievant requested to take leave on March 21, 2016 and March 22, 2016 to assist her mother.

In March 2016, the Assistant Commissioner decided to transfer Grievant from the Facility to the Central Office. He decided to transfer Grievant because of (1) her inability to correct the nursing intervention deficiencies at the Facility, (2) Grievant complained about working with the Facility Administrator, (3) Grievant had inquired about other positions within the Agency and, (4) the Agency wished to apply for a federal grant and needed to utilize Grievant's skills to meet the performance objectives of the grant. In an email dated March 20, 2016 to a Human Resource Manager, the Assistant Director explained:

[14] Agency Exhibit R.

[15] Agency Exhibit R..

> During the exit interview, CMS reported that their last three visits revealed a continued pattern of lack of nursing interventions and patient engagement in treatment. For example, five out of nine charts in the last survey did not contain nursing interventions. ***
>
> The pattern of failing to provide consistent nursing interventions and to engage patients in treatment, places [the Facility] at significant risk for CMS decertification. It is difficult to overstate the significance of CMS decertification as it relates to the loss of revenue for DBHDS and the loss of public confidence in DBHDS' ability to provide quality care to those it is responsible to serve.[16]

The Facility Administrator sent Grievant an email on March 17, 2016 requiring Grievant to report to the Facility on March 21, 2016 "to meet with our consulting team."[17] Grievant asked why she needed to come to the Facility. The Facility Administrator untruthfully told her the meeting was to discuss CMS. Grievant arrived at the Facility. The Facility Administrator gave her a letter telling her she was being transferred to the Central Office for at least six months. Grievant was given a new Employee Work Profile with the same salary, pay band, and title. Grievant became ill. She was unable to return to work. She did not report to the Central Office to perform the duties of her new assignment. She remained on leave until her removal.

The CMS sent the Facility Administrator a letter dated April 7, 2016 advising:

> Our letter dated March 31, 2016 stated that [the Facility] will be terminated from the Medicare program on April 21, 2016. As CMS is required to give concurrent notice to the public of the termination action, we are revising the termination to be effective April 22, 2016.[18]

After the Assistant Commissioner decided to transfer Grievant, the Virginia Department of Health received a complaint regarding the Facility and conducted an onsite investigation of the Facility. The Virginia Department of Health's Office of Licensure and Certification sent the Facility Administrator a letter dated April 19, 2016 stating, in part:

> An unannounced Medicare/Medicaid Complaint … investigation, for the above facility, was conducted on March 31, 2016 through April 01, 2016 and April 04, 2016 through April 06, 2016 by two Medical Facilities Inspectors from the Virginia Department of Health – Office of Licensure and Certification. The complaint was investigated and substantiated.

[16] Grievant Exhibit 3.

[17] Grievant Exhibit 3.

[18] Agency Exhibit S.

Information obtained at the time of the survey indicated that your facility was found not in compliance with 42 CFR 482, the Medicare/Medicaid Conditions of Participation for Hospitals. Immediate Jeopardy was identified in the following area at the Condition level:

42 CFR 482.13 Patient Rights

Information presented to the surveyors during the investigation was accepted and the Immediate Jeopardy was lifted on April 4, 2016.[19]

The CMS Statement of Deficiencies stated, in part:

A 144
***

On 3/31/16 a tour of the secured hallway was conducted with Staff Member #2 and #7. Staff Member #7 stated, "A minimum of two (2) staff members are in the hallway at all times when patients are in the hallway. There is always a staff member standing at the bathroom door if a patient is in the bathroom." Staff Member #8 was interviewed the same day and stated, "There is always one nursing staff person in group or in the hallway." ***

Staff Member #5 picked 3/30/16 from 10:45 a.m. to 11:15 a.m. The recording showed a female patient being escorted to the bathroom (two locked rooms, one for male patients and one for female patients), situated in [an] alcove on the secured hallway … and a few seconds later a male patient being escorted by another staff member to the bathroom. No staff member remained at the bathroom doors. The male patient left the bathroom approximately 37 seconds after entering[;] the female patient left the bathroom approximately 2 minutes and 42 seconds. One staff member could be seen in the hallway part of the time. There was [a] period of time (approximately 3 minutes) when there was no visible staff in the hallway.[20]

Because of the Facility's termination from the Medicare program, the Agency hired a Consultant to review the Facility's operations. On April 27, 2016, the Consultant issued its report based on a review of the Facility conducted from April 12, 2016 through April 14, 2016. The purpose of the site visits was to evaluate the Facility Nursing Department and the Facility's difficulties in complying with CMS Special Conditions for Medical Records.

[19] Agency Exhibit T.

[20] Agency Exhibit T..

The Consultant had conducted previously an on-site review in May 19, 2015 and May 20, 2015 at the same time a survey was performed by the Joint Commission and a number of CMS visits.

The Consultant pointed out that the Agency was able to resolve two of the three conditions of participation (CoP) for which the Facility was found non-compliant. The CoP relating to Medical Records, however, remained out of compliance. The Consultant found, in part:

> It does not appear that nursing quality indicators are adequately in place. Falls, patient incidents, restraint and seclusion are monitored but nursing has not been an active participate in the Quality Improvement Program. Nursing leaders indicate that there have not been ongoing leadership meetings and thus the agenda has not included continuous quality improvement or nursing intervention training programs. ***
>
> B148 (Nursing Care): Nursing documentation is still not individualized and often the same intervention language is used for multiple patients. B148 (Nursing Care): There is insufficient evidence to suggest [Grievant] or current interim Director of Nursing monitored or evaluated the nursing care provided as there was no evidence of medical record monitoring nor was the use of nursing-sensitive quality indicators apparent.[21]

The Assistant Commissioner decided to issue Grievant two Group III Written Notices with removal. He considered Grievant's length of service and work performance. He considered Grievant's concerns about inadequate nurse staffing. He considered Grievant's response to the Agency's allegations.

CONCLUSIONS OF POLICY

Unacceptable behavior is divided into three types of offenses, according to their severity. Group I offenses "include acts of minor misconduct that require formal disciplinary action."[22] Group II offenses "include acts of misconduct of a more serious and/or repeat nature that require formal disciplinary action." Group III offenses "include acts of misconduct of such a severe nature that a first occurrence normally should warrant termination."

Failure to follow a supervisor's instructions is a Group II offense.[23]

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[21] Agency Exhibit U.

[22] The Department of Human Resource Management ("DHRM") has issued its Policies and Procedures Manual setting forth Standards of Conduct for State employees.

[23] See, Attachment A, DHRM Policy 1.60.

Group III Written Notice – Nursing Interventions

The June 5, 2015 survey revealed deficiencies with documenting nursing interventions at the Facility. Grievant was instructed by the Facility Administrator to correct the deficiencies. Grievant participated in creating the Plan of Correction and understood her obligations.

The October 14, 2015 survey again showed nursing interventions were deficient. This second survey report stated that "the Director of Nursing failed to … [d]evelop individualized nursing interventions that addressed specific patient needs in nine (9) of nine (9) active sample patients." Grievant again participated in drafting the Plan of Correction. She was responsible for making the necessary changes to nursing services and Facility Operations to ensure that the Facility satisfied CMS nursing services intervention standards.

The February 24, 2016 survey showed that nursing interventions were deficient. The Statement of Deficiencies specified that Grievant failed to ensure nursing interventions were documented on the MTPS for four (4) of nine (9) active sample patients.

The Agency hired a Consultant to review the Facility's operations. The Consultant found that (1) there had not been ongoing leadership meetings and thus the agenda had not included continuous quality improvement or nursing intervention training programs, (2) nursing documentation was not individualized and often the same intervention language was used for multiple patients, and (3) there was insufficient evidence to suggest [Grievant] or current interim Director of Nursing monitored or evaluated the nursing care provided as there was no evidence of medical record monitoring nor was the use of nursing-sensitive quality indicators apparent.

The Agency has presented sufficient evidence to show that Grievant was instructed to correct nursing intervention deficiencies and failed to comply with that instruction. Grievant was informed of the deficiencies identified by CMS. She knew she was obligated to correct those deficiencies in accordance with two Plans of Correction.

The surveys showed that Grievant was responsible for the nursing intervention deficiencies. The Agency concluded that Grievant was responsible for the nursing intervention deficiencies. The Consultant confirmed that Grievant was responsible for the nursing deficiencies.

Key evidence in this case showed a pattern of nursing intervention documentation deficiencies. Three surveys were conducted from June 2015 to February 2016 that revealed nursing intervention deficiencies. In addition, the patients with deficient documentation of nursing interventions were admitted on various dates. These factors show an ongoing pattern of failure by Grievant to properly manage and correct nursing intervention documentation deficiencies. Accordingly, Grievant failed to

comply with an instruction to correct nursing deficiencies thereby justifying the issuance of a Group II Written Notice.

In certain extreme circumstances, an offense listed as a Group II Notice may constitute a Group III offense. Agencies may consider any unique impact that a particular offense has on the agency. (For instance, the potential consequences of a security officer leaving a duty post without permission are likely considerably more serious than if a typical office worker leaves the worksite without permission.)

The Agency elevated the disciplinary action from a Group II Written Notice to a Group III Written Notice because Grievant held the Facility's highest nursing management position and the loss of Medicare funding jeopardized the Agency's ability to provide services to its patients. The Agency's decision to elevate the disciplinary action is supported by the evidence. The consequence of losing Medicare funding was materially significant to the Facility's financial operations. Grievant's failure to correct nursing intervention deficiencies was one of several reasons why the Facility lost Medicare funding. Grievant's management position placed her in the position to control whether the Facility's nursing intervention documentation was satisfactory to CMS.

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 performed her job as expected. She argued she recognized the problems and appropriately delegated tasks to other employees who were responsible for the problems identified during the surveys. For example, on September 10, 2015, Grievant sent a memorandum to her Registered Nurse Coordinators expressing Grievant's expectation that all staff be trained regarding the items outlined in the PoC. She added that "CMS and Joint Commission will revisit us and it is imperative that staff are trained."[24] Grievant testified that she conducted spot checks of medical records and trained staff who failed to correctly complete medical records.

It is clear that Grievant took some steps to correct problems with medical record documentation. It is also clear that many of the steps she took were unsuccessful. For example, after sending a memorandum to her Registered Nurse Coordinators on September 10, 2015, a survey conducted on October 14, 2015 showed that the treatment plan interventions for nine of nine patients were inadequate. Six of those nine patients had plans of treatment dated after September 10, 2015. The steps Grievant took to correct deficiencies were inadequate.

Grievant argued that she properly delegated tasks to her subordinates but the subordinates failed to comply with her instructions. In many cases, Grievant lacked an assistant chief nursing executive to assist her. Although Grievant's job likely would

[24] Agency Exhibit V.

have been easier with additional supervisory staff, the burden the Agency placed on her without having those staff was not unreasonable.

Grievant argued that the loss of Medicare funding was not the result of the actions of one person. The Agency did not dispute this assertion. The Agency, however, has established that Grievant was one of the key employees causing the loss of Medicare funding.

Mitigation

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 Human Resource Management …."[25] 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-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. In light of this standard, the Hearing Officer finds no mitigating circumstances exist to reduce the Group III Written Notice with removal regarding nursing interventions.

Group III Written Notice – Plan of Correction Regarding Sexual Assault

The Agency alleged that Grievant failed to implement the Plan of Correction to reduce the risk of sexual assault of patients as instructed by her supervisor.

It appears that the Agency contends Grievant should have ensured that a staff member remained posted in front of the restroom doors even when patients were not inside a restroom. In addition, a staff member should have escorted a patient from the group services room to the restroom and remained outside the restroom until the patient was finished using the restroom and then escorted the patient back to the group services room.

The Agency has not established this allegation for several reasons. First, the Agency's instructions did not clearly state that an employee had to remain outside of the restroom at all times even when a patient was not inside the restroom. Grievant was informed:

[25] Va. Code § 2.2-3005.

- Staff to open bathroom door and stay outside the bathroom until patient leaves the bathroom.
- The locked bathrooms and the staff monitor at the bathroom door will be the resource that the group facilitator needs.

If a staff monitor at the bathroom door was a resource to the group facilitator, he or she may find it necessary to walk away from the restroom door to assist the group facilitator.

Second, Grievant was no longer employed at the Facility on March 30, 2016 when the video showed staff were not properly monitoring the restrooms. It is possible Grievant's absence affected the intensity of her staff's performance.

Third, the Agency did not establish a pattern of staff failing to properly monitor the restrooms that included the months Grievant was employed at the Facility. It may be the case that the video of March 30, 2016 depicted was an aberration from the customary practice of staff. The Group III Written Notice regarding patient safety must be reversed.

March 21, 2016 Transfer

Grievant filed a grievance challenging the Agency's decision to transfer her on March 21, 2016. Grievant argued that the transfer was disciplinary in nature. The Hearing Officer can assume for the sake of argument that this allegation is true but it does not affect the outcome of this case. Because one of the two Group III Written Notices with removal is being upheld, Grievant would not be returned to the Agency even if the transfer was reversed.

Grievant argued the Agency interfered with her FMLA leave. Assuming for the sake of argument that this allegation is true, it is unclear what remedy is available to the Hearing Officer. The Hearing Officer cannot award damages. It is unclear whether the Agency reduced Grievant's leave balances even though she reported to work on March 21, 2016.

Grievant argued that the Facility Administrator subjected her to a pattern of abusive and demeaning treatment. Grievant established that the Facility Administrator was untruthful to Grievant regarding the reason why he instructed her to report to work on March 21, 2016. It is unclear the Hearing Officer has any remedy to provide Grievant regarding the Facility Administrator's behavior. He would be subject to disciplinary action for being untruthful, but the Hearing Officer does not have authority to compel the Agency to take disciplinary action against an employee. Since Grievant is not being reinstated, she would not be subject to any future abusive and demeaning treatment.

Grievant's request for relief must be denied.

DECISION

For the reasons stated herein, the Agency's issuance to the Grievant of a Group III Written Notice of disciplinary action with removal for failure to implement a plan of correction thereby placing patients in immediate jeopardy is **rescinded**. The Agency's issuance to the Grievant of a Group III Written Notice of disciplinary action with removal for failure to consistently develop, implement, and evaluate nursing standards is **upheld**. Grievant's request for relief regarding her March 21, 2016 transfer is **denied**.

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
   Department of Human Resource Management
   101 North 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 North 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.[26]

[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/ Carl Wilson Schmidt

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Carl Wilson Schmidt, Esq.
Hearing Officer

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