Issues: Group III Written Notice (falsify records), Group III Written Notice (failure to follow policy), and Termination; Hearing Date: 06/16/14; Decision Issued: 07/06/14; Agency: DBHDS; AHO: Ternon Galloway Lee, Esq.; Case No.10348, 10349; Outcome: No Relief – Agency Upheld.

# DECISION OF HEARING OFFICER

**In the matter of**
**Case Numbers: 10348 and 10349**
**Hearing Date: June 16, 2014**
**Decision Issued: July 6, 2014**

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## SUMMARY OF DECISION

The Agency had found Grievant falsified records. It then issued Grievant a Group III Written Notice with removal. In addition, the Agency had found Grievant violated Departmental Instruction (DI) DI 201 and Agency Policy # 050-57, and it then issued Grievant another Group III Written Notice with removal. The Hearing Officer found Grievant engaged in the behaviors alleged and they were misconduct. Finding the Agency's discipline was consistent with policy, the Hearing Officer upheld the Group III Written Notices with termination.

## HISTORY

On March 25, 2014, the Agency issued Grievant two Group III Written Notices. Each terminated Grievant's employment. More specifically, one of the notices alleged Grievant falsified records; the other asserted that Grievant violated DI 201 and Agency Policy # 050-57 "Reporting and Investigating Abuse and Neglect of Clients." On March 26, 2014, Grievant timely filed grievances challenging the Agency's discipline. By order entered April 10, 2014, the Office of Employment Dispute Resolution (EDR) consolidated the grievances. Further, on April 29, 2014, EDR assigned the undersigned as the hearing officer to the appeals.

The Hearing Officer held a telephonic prehearing conference (PHC) on May 9, 2014.[1] Based on discussions during the PHC, the Hearing Officer found the first available date for the hearing was June 16, 2014. Accordingly, by agreement of the parties, the hearing was set for that date. On May 18, 2014, the Hearing Office issued a scheduling order addressing those matters discussed and ruled on during the PHC.

On the date of the hearing and prior to commencing it, the parties were given an opportunity to present matters of concern to the Hearing Office. None were presented. During the hearing the Hearing Officer admitted Agency Exhibits 1 through 13 to which Grievant did not object. Grievant was provided an opportunity to present exhibits, but declined to do so.

At the hearing both parties were given the opportunity to make opening and closing statements and to call witnesses. Each party was provided the opportunity to cross examine any witnesses presented by the opposing party.

During the proceeding, the Agency was represented by its advocate. Grievant represented herself.

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[1] This was the parties' first date available for the PHC.

## APPEARANCES

Advocate for Agency
Witnesses for the Agency (5 witnesses)
Grievant
Witnesses for Grievant (4, including Grievant)

## ISSUE

Were the written notices warranted and appropriate under the circumstances?

## BURDEN OF PROOF

The burden of proof is on the Agency to show by a preponderance of the evidence that its disciplinary actions against Grievant were warranted and appropriate under the circumstances. Grievance Procedure Manual ("GPM") § 5.8(2). 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 all the evidence presented and observing the demeanor of each witness, the Hearing Officer makes the following findings of fact:

1. The Agency is a Department facility. Specifically, it is a mental health hospital. Grievant worked the night shift at the Agency. She was employed as a licensed practical nurse (LPN) in the hospital's geriatric unit, also known as Pod 4. The shift was exceedingly short staffed. Her tasks, among others, included providing wound care to patients. As such, changing a wound's dressing as ordered by a patient's physician was a part of her responsibility. (Testimonies of CNA, LPN 1, MDS Coordinator, LPNs 1 and 2; A Exhs. 9 and 10).

2. Wound care is important to prevent infections and promote healing of a wound. (Testimonies Clinical Nurse Specialist and MDS Coordinator).

3. Special rounds are made at the hospital once a week by a team of health care professionals (wound care team/team) that are also employed by the Agency. Normally the team consists of a physician or nurse practitioner, an occupational therapist, and the MDS Coordinator. During the rounds, the team customarily strips a patient's wound, takes pictures of it to measure its recovery, and redresses the wound. (Testimonies of MDS Coordinator and Clinical Nurse Specialist).

4. Patient X is a resident or client in Pod 4 of the Agency. He holds an Axis I diagnosis of Dementia due to head trauma, with behavioral disturbance and Mood disturbance due to Head Trauma. In addition, under Axis II, the patient is diagnosed with mental retardation. He is treated by the hospital for his mental impairments. (A Exh. 8, p. 1).

Patient X also had a wound on his buttocks area. Among other duties, Grievant was assigned the task of redressing the wound consistent with the physician's order. Particularly, she was required to remove the dressing from the wound at least every third day, clean it with saline, apply Santyl ointment on the wound to remove the dead tissue, and redress the wound. Changing the dressing every three days was important to prevent bacterial from growing and an infection. Redressing was required more frequently than every three days if the dressing was soiled or non-adherent. Because the Santyl ointment was critical to treating Patient X's wound, Grievant was expected to assure the Santyl ointment did not run out. Therefore, when the supply of it was low, Grievant was expected to order more. Grievant was required to assure that the ointment was kept in Patient's treatment bag. (Testimonies of Clinical Nurse Specialist, Director of Nursing, and MDS Coordinator; A Exh. 8, D 1.3).

5. Per policy, once a wound is dressed, whether by a member of the wound care team or the nurse assigned to care for the patient's wound, the date of the dressing and employee who prepared it must be written on the dressing. (Testimony of Clinical Nurse Specialist).

6. In addition to initialing and dating the dressing, Agency policy required nurses to document the date they changed a dressing. This was done on a form identified as the Treatment Administration Record (TAR). Specifically, on the date a nurse changed a dressing, the nurse was required to initial on the applicable line of the TAR indicating the dressing had been changed on that date. If an "O" was placed on that line instead, it indicated the dressing was not changed. Further documentation was expected to explain any "O" entry. An "X" placed on the line indicated that the physician's order did not require the wound to be dressed on that date. (A Exh. 8, D.1.3; Testimonies of MDS Coordinator, Director of Nursing, Nursing Director, and Clinical Nurse Specialist).

7. While the wound care team was making its rounds on March 11, 2014, the team observed what appeared to be a stool around Patient X's wound. Also, the wound had a foul smell. When it was opened, the team discovered that the wound had increased in size and a new pressure ulcer had opened. In addition, although the patient's physician had ordered the wound's dressing be changed every third day, the date on the dressing was March 5, 2014, six days earlier. Moreover, there was no Santyl ointment present in the patient's treatment bag. This implied that application of this ointment to Patient X's wound was not occurring. As referenced above, this treatment was necessary to remove dead tissue from the wound and foster healing. (A Exh. 8, p. 2 and D.1.3; Testimonies of MDS Coordinator and Clinical Nurse Specialist).

8. The condition of Patient X's wound prompted a review of the TAR. This record showed the following:

(i) On March 4, 2014, Grievant initialed that she changed Patient X's dressing;

(ii) On March 5, 2014, the TAR indicated a wound team member changed the patient's dressing;

(iii) On March 7, 2014, Grievant placed an "O" on the designated line for that

date and documented that she did not change the dressing because it had been completed on March 5, 2014, by the wound care team;

(iv) On March 8, 2014, Grievant placed an "X" on the designated line for that date indicating, the physician's order did not require her to change the dressing;

(v) On March 10, 2014, Grievant placed her initial on the designated line for that date indicating she had redressed Patient X's wound.

(Testimonies of Grievant and Clinical Nurse Specialist; A Exh. 8, D.1.3).

9. Grievant had not redressed Patient X's wound on March 10, 2014. (Testimony of Grievant).

10. The Agency launched an investigation, because there was a discrepancy in the TAR notation and the condition of the wound's dressing regarding when the wound was redressed. Particularly, as noted above, the dressing indicated that the last change occurred on March 5, 2014, and the TAR indicated the wound was last dressed on March 10, 2014. Observations of the wound on March 11, 2014, demonstrated that it could not have been freshly redressed the day before. When Grievant was questioned about the conflicting dates, Grievant stated she initialed the TAR on March 10, 2014, intending to redress the wound, but she became distracted. Further, she indicated that she was attending school to advance in her career and had to leave at the end of her shift for clinical nursing. (Testimonies of Investigator, Director of Nursing, Licensed Nursing Home Administrator, and Grievant).

11. If a nurse is not able to complete a task prior to her shift ending, the nurse is required to report the situation to the "charge nurse." The physician is required to be notified and a plan implemented so that the task can be completed by other staff. Grievant did not report to the charge nurse that she was unable to change Patient X's dressing on March 10, 2014. As a result, no plan was developed so that redressing could be done. (Testimony of Director of Nursing).

12. Grievant was required to follow the physician's order and redress Patient X's wound every three days or sooner if the dressing was soiled or non-adherent. This order remained effective even if the wound care team made its rounds and redressed the patient's wound in between the three days. The only exception to this procedure was if the wound care team redressed a wound on the same day the Grievant was required to dress it pursuant to the physician's order. Under this special situation, no dressing would be required by Grievant on that day. (Testimonies of Director of Nursing, Licensed Nursing Home Administrator, and MDS Coordinator).

13. Grievant asserted that because the wound's dressing was changed on March 5, 2014, she was not required to change it on March 7, 2014. Assuming Grievant should have redressed the wound three days after the wound care team dressed it on March 5, 2014, Grievant would have been required to change the dressing on March 8, 2018. (Testimonies of LPN 1 and Investigator). The TAR demonstrates that Grievant did not redress the patient's wound on

March 8, 2014. (Testimony of Investigator; A Exh. 8, p. 3).

14. The Agency issued Grievant a Group III Written Notice for falsification of records on March 7, 2014, and March 10, 2014, with termination. It also issued Grievant a Group III Written Notice for violating DI 201 and Agency Policy # 050-57 "Reporting and Investigating Abuse and Neglect of Clients" on or about March 11, 2014. (Testimony of Licensed Nursing Home Administrator; A Exhs. 1, 4, and 6).

15. Prior to Grievant's termination she had been employed by the Agency for four years as a CNA and 12 years as an LPN. During her employment, Grievant had never received a written group notice. On March 10, 2014, Grievant was ill and had not slept for 24 hours. (Testimony of Grievant).

16. Agency policy does not condone nurses documenting that they have completed a task when they have not. Engaging in such behavior is a misrepresentation. (Testimonies of LPN 1, LPN 2, and Licensed Nursing Home Administrator).

## DETERMINATIONS 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/her 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).

*Va. Code* § 2.2-3000 (A) 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 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.[2]

To establish procedures on Standards of Conduct and Performances for employees of the Commonwealth of Virginia and pursuant to § 2.2-1201 of the *Code of Virginia*, the Department of Human Resource Management promulgated Standards of Conduct Policy No. 1.60 (Policy 1.60). The Standards of Conduct provide a set of rules governing the professional and personal

[2] Grievance Procedural Manual §5.8

conduct and acceptable standards for work performance of employees. The Standards serve to establish a fair and objective process for correcting or treating unacceptable conduct or work performance, to distinguish between less serious and more serious actions of misconduct and to provide appropriate corrective action.

Under the Standards of Conduct, Group I offenses are categorized as those that are less severe in nature, but warrant formal discipline; Group II offenses are more than minor in nature or repeat offenses. Further, Group III offenses are the most severe and normally a first occurrence warrants termination unless there are sufficient circumstances to mitigate the discipline. *See* Standards of Conduct Policy 1.60.

On March 25, 2014, management issued Grievant two Group III Written Notices with removal for the reasons stated in the above section. The Hearing Officer examines the evidence to determine if the Agency has met its burden.

## I. Analysis of Issue(s) before the Hearing Officer

**Issue: Whether the discipline was warranted and appropriate under the circumstances?**

### A. Did the employee engage in the falsification of a record and abuse or neglect a client? Further, if so did that behavior constitute misconduct?

#### 1. Falsification of Record

The Agency contends that Grievant falsified a record when she initialed the TAR on March 10, 2014, indicating that she had redressed Patient X's wound on that date. The evidence shows that Grievant concedes she failed to redress the patient's wound on March 10, 2014. Yet Grievant documented on the TAR that she had completed that task. Grievant explains her action by noting that she made the recording with the intent of completing the task, but she became distracted and never redressed the wound. Grievant offers that there was no intent to deceive. And also, she was in school and needed to leave work at the end of her shift to attend nursing clinicals.

The Agency's Licensed Nursing Home Administrator testified that Grievant's conduct constituted the falsification of a record. The evidence supports this assessment. Specifically, Grievant's misconduct is corroborated by her own witnesses. To this point, Grievant's witnesses were asked "If they would document that they had completed a task if they had not done the work." In response, Grievant's witness LPN1 testified that it would be dishonest to indicate you have done the work and you have not. She described such a misrepresentation as "dishonest." Likewise, another witness of Grievant, LPN2, testified that to document completing a task when it has not been done would be "a falsification." In like manner, Grievant's witness CNA testified that she would not document accomplishing an assignment when she had not. Moreover, of particular note, the evidence demonstrates that two of Grievant's witnesses were LPNs, and like Grievant they also were responsible for wound care. Yet neither condoned the practice of an LPN documenting that she/he had treated a wound when such had not been

accomplished.

Bearing in mind the above, the Hearing Officer finds that Grievant documented that on March 10, 2014, she had redressed Patient X's wound. Undoubtedly, she had not. Grievant's explanation to excuse her behavior is unconvincing. Hence, the Hearing Officer finds Grievant's action on March 10, 2014 constituted record falsification.[3]

### 2. Client Abuse and Neglect

The Agency also contends Grievant abused and or neglected Patient X in violation of DI 201 and Agency Policy # 050-057.

#### (a) DI 201

First, the Hearing Officer considers the Agency's contention regarding DI 201. The evidence shows that this policy is an instruction by the Department that applies to the Agency. In pertinent part, DI 201 defines abuse as follows:

> …[A]ny act or failure to act by an employee or other person responsible for the care of an individual in a Department facility that was performed or was failed to be performed knowingly, recklessly or intentionally, and that caused or might have caused physical or psychological harm, injury or death to a person receiving care or treatment for mental illness, mental retardation or substance abuse.

In pertinent part, this policy also defines neglect as follows:

> …[T]he 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.

Now, the Hearing Officer examines the facts to determine if Grievant violated DI 201.

The evidence shows that Grievant was an LPN in the geriatric unit of the hospital. Among other duties, she was responsible for treating and redressing Patient X's wound which was located in the patient's buttock area. This patient carried a diagnosis of dementia and was mentally retarded. The Agency provides treatment to this patient due to his mental impairments.

The evidence also demonstrates that by physician order, Grievant was required to redress the patient's wound every three days. This was the policy even if the wound care team dressed the wound in between Grievant's treatment.[4] Adhering to the wound dressing order was critical to Patient X's care to prevent the wound from becoming infected and to foster its healing.

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[3] The evidence was insufficient to find Grievant falsified a record on March 7, 2014.
[4] There was one exception referenced in "Finding of Fact" 12; however, this exception is inapplicable here.

In spite of the physician's order, the evidence shows Grievant neglected providing treatment in several ways. For example, the evidence shows Grievant dressed the wound on March 4, 2014. Accordingly, under the physician's order, Grievant was required to treat it again on March 7, 2014, and once again on March 10, 2014. The evidence demonstrates Grievant failed to do so. Her explanation for neglecting the treatment on March 7, 2014, was she did not have to redress the wound because the wound care team had done so on March 5, 2014. Grievant explained that therefore the wound was not due to be redressed again until the third day following March 5, 2014. That date would have been March 8, 2014. Of particular note, the evidence establishes that even by Grievant's treatment schedule, she disregarded dressing the wound on March 8, 2014. Grievant has offered no reason for failing to redress the wound according to what she determined the treatment schedule to be. What is more, in addition to Grievant not dressing the wound on March 7 or 8, 2014, she also failed to do so on March 10, 2014. This day was another date under the physician's order that Grievant was required to treat Patient X's wound.

Secondly, the evidence demonstrates that the physician's order also required Grievant to apply Santyl cream to the wound during each three day treatment to remove the dead tissue in the wound. This treatment was critical for the wound to heal. The evidence establishes that Grievant did not maintain a supply of the ointment in the patient's treatment bag as she was required to do. In addition, Grievant left work on March 10, 2014, before treating the wound. Grievant explained that she intended to change the dressing, but the shift was grossly understaffed. She further stated that she was distracted and had to leave at or near the end of her shift to report to nursing clinicals. To this point, the evidence shows that pursuant to policy, if a nurse is unable to complete an assignment, she must inform the charge nurse. Moreover, the physician must be notified and a plan developed so that the incomplete work can be accomplished. Grievant failed to follow protocol. She simply documented that the dressing was done and left work without notifying the charge nurse that she had not changed the dressing. As a result, the geriatric and mentally retarded patient went six days without the Santyl ointment being applied and the dressing being changed. When the wound care team observed the patient's wound on March 11, it had enlarged[5] and carried a foul odor. The evidence shows that this lack of physician-ordered care was detrimental to the wound healing properly.

In summary, Grievant had the responsibility to redress Patient X's wound on March 7, 2014, and March 10, 2014, under the physician's order and Agency protocol. She did not. Also, Grievant failed to maintain a supply of the Santyl ointment for wound treatment. In addition, Grievant left work on March 10, 2014, without communicating that she had not treated the patient's wound. Even worse, she misled the Agency by documenting that wound care had occurred. Such treatment was necessary for recovery of the wound and to prevent infections. Considering the evidence, the Hearing Officer finds Grievant engaged in the conduct alleged regarding abuse and neglect and it was misconduct.

**(b) Policy 050-057**

[5] The evidence was insufficient to show that failure to redress the wound caused it to increase in size. (A Exh. 8, p. 5).

Similar to DI 201, in pertinent part, Agency Policy 050-057 defines abuse as follows:

> Any act or failure to act by an employee or other person responsible for the care of a patient that was performed or not performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury or death to a person.

Also, Agency Policy 050-057 defines neglect as follows:

> The 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 in the facility.

For the reasons already discussed above regarding DI 201, the Hearing Officer finds Grievant's conduct constituted abuse and neglect under the Agency Policy 050-057 as well.

### B. Was the discipline consistent with policy and law?

Group III Offenses are serious in nature. Usually a first offense warrants termination. Attachment A to Policy 1.60 of the Standards of Conduct identifies the falsification of records as a Group III Offense. Moreover, the Department and Agency maintain a zero tolerance for abuse and neglect, thus indicating the seriousness of such an offense. Also, Grievant's actions were careless and detrimental to the health and safety of Patient X. Accordingly, the Hearing Officer finds that due to the seriousness of the offenses, the Agency's issuance of two Group III Written Notices with termination was consistent with policy and law.

## II. Mitigation.

Under statute, hearing officers have the power and duty to "[r]eceive and consider evidence in mitigation or aggravation of any offense charged by an agency in accordance with the rules established by the Office of Employment Dispute Resolution ["EDR"]."[6] EDR's *Rules for Conducting Grievance Hearings* provides that "a hearing officer is not a super-personnel officer'" therefore, "in providing any remedy, the hearing officer should give the appropriate level of deference to actions by agency management that are found to be consistent with law and policy."[7] More specifically, the *Rules* provide that in disciplinary, grievances, if the hearing officer finds that;

(i) the employee engaged in the behavior described in the Written Notice.

(ii) the behavior constituted misconduct, and

(iii) the agency's discipline was consistent with law and policy, the agency's discipline must be upheld and may not be mitigated,

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[6] Va. Code § 2.2-3005 and (c )(6)

[7] *Rules for Conducting Grievance Hearings* VI(A)

unless, under the record evidence, the discipline exceeds
the limits of reasonableness.[8]

Thus, the issue of mitigation is only reached by a hearing officer if he or she first makes the three findings listed above. Further, if those findings are made, a hearing officer must uphold the discipline if it is within the limits of reasonableness.

The Hearing Officer has found that Grievant engaged in the conduct described in the group notices and that the behaviors were misconduct. Further, the Hearing Officer has found, the Agency's discipline was consistent with policy and law.

Next, the Hearing Officer considers whether the discipline was unreasonable. In her plea for mitigation Grievant presents her 16 years of employment with the Agency. She touts never receiving a group notice during her employment tenure with the Agency. Grievant also contends on March 10, 2014, she had intentions of changing the dressing, but she was distracted. She testified that she had not had any sleep and left work to go directly to school for nursing clinicals. She reports her shift was extremely understaffed.

The Hearing Officer has considered all of Grievant's arguments and all evidence whether specifically mentioned or not. She notes aggravating circumstances in this case to include numerous violations of Agency policy, misrepresentation, and the detriment to a mentally retarded and geriatric patient with dementia. Under the circumstances in this case, the Hearing Officer cannot find the Agency acted unreasonable when it disciplined Grievant.

## DECISION

Hence for the reasons stated here, the Hearing Officer upholds the Agency's discipline.

## 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
Departmental of Human Resource Management
101 N. 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

[8] *Rules for Conducting Grievance Hearings* VI(B)

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 N. 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.[9]

Entered this 6th day of July, 2014.

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Ternon Galloway Lee, Hearing Officer

cc: Agency Advocate/Agency Representative
Grievant
EDR's Director

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