Issue: Administrative Review of Hearing Officer's Decision in Case No. 10856, 10863; Ruling Date: April 6, 2017; Ruling No. 2017-4525; Agency: Department of Behavioral Health and Developmental Services; Outcome: Hearing Officer's decision affirmed.

COMMONWEALTH of VIRGINIA

Department of Human Resource Management

Office of Employment Dispute Resolution[1]

ADMINISTRATIVE REVIEW

In the matter of the Department of Behavioral Health and Developmental Services
Ruling Number 2017-4525
April 6, 2017

The grievant has requested that the Office of Employment Dispute Resolution ("EDR") at the Virginia Department of Human Resource Management ("DHRM") administratively review the hearing officer's decision in Case Number 10856/10863. For the reasons set forth below, EDR will not disturb the hearing decision.

FACTS

The relevant facts in Case Number 10856/10863, as found by the hearing officer, are as follows:[2]

> The Department of Behavioral Health and Developmental Services employed Grievant as a Chief Nurse Executive 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 for the provision of safe and competent Nursing Care; for accomplishing the goals and objectives of the Hospital and overseeing the Nursing Department.
>
> 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

[1] Effective January 1, 2017, the Office of Employment Dispute Resolution merged with another office area within the Department of Human Resource Management, the Office of Equal Employment Services. Because full updates have not yet been made to the *Grievance Procedure Manual*, this office will be referred to as "EDR" in this ruling to alleviate any confusion. EDR's role with regard to the grievance procedure remains the same post-merger.

[2] Decision of Hearing Officer, Case No. 10856/10863 ("Hearing Decision"), March 3, 2016, at 2-13 (citations omitted).

participation in treatment planning." 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]. 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.

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.

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.

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.

- 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.

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, 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. ***

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.
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

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 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.
>
> 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.

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:
> 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.

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.

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. ***

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.

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:

> 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.

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." 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.

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.
>
> 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.
>
> 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.

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.

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.

> 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.

The grievant was transferred from the Facility to the Central Office on March 21, 2016.[3] On June 22, 2016, the grievant was issued a Group III Written Notice with removal for failure to implement a plan of correction thereby placing patients in immediate jeopardy,[4] and a second Group III Written Notice with removal for failure to consistently develop, implement, and evaluate nursing standards.[5] The grievant filed timely grievances to challenge her transfer to the Central Office (prior to her termination) and the Written Notices,[6] and a hearing was held on September 26, 2016.[7] In a decision dated March 3, 2017, the hearing officer concluded that the agency had not presented sufficient evidence to justify the issuance of the first Written Notice and rescinded it.[8] The hearing officer further determined that the agency's decision to issue the second Written Notice was supported by the evidence and upheld the grievant's termination, and found that no relief was available in relation to the grievant's challenge to her transfer to the Central Office.[9] The grievant now appeals the hearing decision to EDR.

DISCUSSION

By statute, EDR has been given the power to establish the grievance procedure, promulgate rules for conducting grievance hearings, and "[r]ender final decisions . . . on all matters related to . . . procedural compliance with the grievance procedure."[10] If the hearing officer's exercise of authority is not in compliance with the grievance procedure, EDR does not award a decision in favor of either party; the sole remedy is that the hearing officer correct the noncompliance.[11]

In her request for administrative review, the grievant asserts that the hearing officer erred in upholding the issuance of the Group III Written Notice for failing to consistently develop, implement, and evaluate nursing standards. Specifically, the grievant appears to argue that (1) her behavior did not constitute misconduct because "she wasn't alone responsible for [the] CMS failures" that were the agency's basis for the issuance of the Written Notice; (2) the agency's elevation of the discipline from a Group II Written Notice to a Group III Written Notice was not supported by the evidence; and (3) the hearing officer "should have declared that the Agency violated Grievant's rights under the FMLA" and awarded her relief with respect to that claim.

Hearing officers are authorized to make "findings of fact as to the material issues in the case"[12] and to determine the grievance based "on the material issues and the grounds in the

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[3] Agency Exhibits A, D.
[4] Agency Exhibit G at 1.
[5] *Id.* at 3.
[6] Agency Exhibits A, I.
[7] *See* Hearing Decision at 1.
[8] *Id.* at 1, 16-17.
[9] *Id.* at 14-18.
[10] Va. Code §§ 2.2-1202.1(2), (3), (5).
[11] *See Grievance Procedure Manual* § 6.4(3).
[12] Va. Code § 2.2-3005.1(C).

record for those findings."[13] Further, in cases involving discipline, the hearing officer reviews the facts *de novo* to determine whether the cited actions constituted misconduct and whether there were mitigating circumstances to justify a reduction or removal of the disciplinary action, or aggravating circumstances to justify the disciplinary action.[14] Thus, in disciplinary actions the hearing officer has the authority to determine whether the agency has established by a preponderance of the evidence that the action taken was both warranted and appropriate under all the facts and circumstances.[15] Where the evidence conflicts or is subject to varying interpretations, hearing officers have the sole authority to weigh that evidence, determine the witnesses' credibility, and make findings of fact. As long as the hearing officer's findings are based upon evidence in the record and the material issues of the case, EDR cannot substitute its judgment for that of the hearing officer with respect to those findings.

In the hearing decision, the hearing officer assessed the evidence and concluded that the "Grievant was instructed to correct nursing intervention deficiencies and failed to comply with that instruction," and that she "was informed of the deficiencies identified by CMS" and "knew she was obligated to correct those deficiencies in accordance with two Plans of Correction."[16] The hearing officer further determined that the CMS surveys "showed that Grievant was responsible for the nursing intervention deficiencies" and that "[t]he Consultant confirmed that Grievant was responsible for the nursing deficiencies."[17] The hearing officer found that the grievant's actions constituted failure to follow instructions, a Group II offense, but that the "unique impact" of the misconduct on the agency justified elevation of the discipline to a Group III offense.[18] In particular, the hearing officer noted that "[t]he consequence of losing Medicare funding was materially significant to the Facility's financial operations," that the "Grievant's failure to correct nursing intervention deficiencies was one of several reasons why the Facility lost Medicare funding," and that the grievant's "management position placed her in the position to control whether the Facility's nursing intervention documentation was satisfactory to CMS."[19]

Having reviewed the hearing record, EDR finds that there is evidence in the record to support the hearing officer's conclusions that the grievant was instructed to correct the issues identified in the CMS surveys, that she did not do so, and that her actions had a serious impact on the agency's operations. For example, the CMS surveys noted deficiencies in nursing Services at the facility.[20] The agency developed Plans of Correction to address those deficiencies, one of which explicitly stated that the grievant was responsible for implementing certain corrective actions.[21] At the hearing, the agency presented evidence showing that the grievant's job duties included management of nursing services and implementation of nursing standards at the Facility, that she was tasked with correcting the nursing deficiencies described in the Plans of Correction, and that she did not carry out these responsibilities.[22] As a result of the

[13] *Grievance Procedure Manual* § 5.9.
[14] *Rules for Conducting Grievance Hearings* § VI(B).
[15] *Grievance Procedure Manual* § 5.8.
[16] Hearing Decision at 14.
[17] *Id.*
[18] *Id.* at 14-15.
[19] *Id.* at 15.
[20] *E.g.*, Agency Exhibit L at 1-2; Agency Exhibit M at 84-88; Agency Exhibit P at 40-50; Agency Exhibit R at 15-16.
[21] Agency Exhibit M at 22, 84-85.
[22] Hearing Recording at 46:53-47:15, 58:56-59:23, 1:07:58-1:08:55 (testimony of Assistant Commissioner); Agency Exhibit J; Agency Exhibit U at 3-4.

Facility's continued noncompliance, its CMS certification was terminated.[23] The hearing officer acknowledged that the "Grievant took some steps to correct problems," but noted that "many of the steps she took were unsuccessful" and "inadequate," and found that her actions constituted a failure to follow instructions that justified the issuance of the Written Notice.[24] Conclusions as to the credibility of witnesses and the weight of their respective testimony on issues of disputed facts are precisely the kinds of determinations reserved solely to the hearing officer, who may observe the demeanor of the witnesses, take into account motive and potential bias, and consider potentially corroborating or contradictory evidence. EDR finds no basis to disturb the hearing officer's conclusion that the evidence in the record was sufficient to demonstrate that the grievant engaged in behavior that justified the issuance of the Written Notice in this case.

The grievant appears to be correct that she alone was not responsible for the Facility's loss of CMS certification. Indeed, the agency did not dispute this assertion at the hearing. The Assistant Commissioner testified that other departments and/or employees at the Facility contributed to the loss of certification and corrective action was taken to address those issues.[25] He explained that one employee resigned in lieu of termination.[26] The agency elevated the discipline to a Group III Written Notice with termination because of the expectations for the grievant to implement the Plans of Correction as a senior executive staff member, the public loss of confidence in the agency and the Facility, and the issues presented by the Facility's loss of funding.[27] Attachment A to DHRM Policy 1.60, *Standards of Conduct*, provides that, "in certain extreme circumstances, an offense listed as a Group II Notice may constitute a Group III offense," and that "[a]gencies may consider any unique impact that a particular offense has on the agency" in determining whether elevation is appropriate.[28] In this case, the hearing officer found that the agency has presented evidence to show that the grievant's actions supported elevation to a Group III offense.[29] Determinations of credibility as to disputed facts are precisely the sort of findings reserved solely to the hearing officer. Where the evidence conflicts or is subject to varying interpretations, hearing officers have the sole authority to weigh that evidence, determine the witnesses' credibility, and make findings of fact. Because the hearing officer's findings in this case are based upon evidence in the record and the material issues of the case, EDR cannot substitute its judgment for that of the hearing officer with respect to those findings.

With regard to the grievant's assertion that the hearing officer's conclusions about the agency's actions surrounding her use of FMLA leave were in error, EDR finds that remanding the decision is not warranted in this case. The hearing officer found that "the Facility Administrator was untruthful to Grievant regarding the reason why he instructed her to report to work on March 21, 2016" and considered the grievant's argument that "the Agency interfered with her FMLA leave," concluding that no remedies were available to address these issues because the grievant's termination had been upheld.[30] In her request for administrative review, the grievant asserts that the hearing officer "should have declared that the Agency violated

[23] Agency Exhibit S.
[24] Hearing Decision at 15.
[25] Hearing Recording at 59:36-59:43, 1:20:46-1:22:32 (testimony of Assistant Commissioner).
[26] *Id.* at 2:08:13-2:08:23 (testimony of Assistant Commissioner).
[27] *E.g.*, *id.* at 1:17:43-1:18:59, 1:22:37-1:23:29 (testimony of Assistant Commissioner); Agency Exhibit G at 7-9; Agency Exhibit Z.
[28] DHRM Policy 1.60, *Standards of Conduct*, Attachment A.
[29] Hearing Decision at 15.
[30] *Id.* at 17.

Grievant's rights under the FMLA, and admonished the hospital director to follow the law in the future." In cases where a hearing officer "determines that a policy mandate has been misapplied or applied unfairly," he or she "may order the agency to reapply the policy from the point at which it became tainted" or direct the agency to implement a policy mandate, as appropriate under the circumstances.[31] Even if EDR agrees with the grievant's assertions, a hearing officer cannot award damages or order other relief inconsistent with the grievance procedure.[32] In this case, further relief is unavailable under the grievance procedure to address the grievant's claims about the agency's actions prior to her termination. Even assuming the agency acted improperly, as the hearing officer assumed,[33] any such issues relating to the grievant's use of FMLA leave cannot be corrected here because the hearing officer found that her termination must be upheld.[34]

While the grievant may disagree with the hearing officer's decision, there is nothing to indicate that his consideration of the evidence was in any way unreasonable or not based on the actual evidence in the record. The hearing officer's findings are supported by evidence in the record and the material issues of the case. EDR cannot substitute its judgment for that of the hearing officer with respect to those findings. Accordingly, EDR declines to disturb the decision on the bases cited by the grievant in her request for administrative review.

CONCLUSION AND APPEAL RIGHTS

For the reasons set forth above, EDR declines to disturb the hearing officer's decision. Pursuant to Section 7.2(d) of the *Grievance Procedure Manual*, a hearing decision becomes a final hearing decision once all timely requests for administrative review have been decided.[35] Within 30 calendar days of a final hearing decision, either party may appeal the final decision to the circuit court in the jurisdiction in which the grievance arose.[36] Any such appeal must be based on the assertion that the final hearing decision is contradictory to law.[37]

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[31] *Rules for Conducting Grievance Hearings* § VI(C)(1).
[32] *Grievance Procedure Manual* § 5.9(b).
[33] Hearing Decision at 17.
[34] While there could be certain situations in which an agency's actions prior to an employee's termination could be susceptible to relief under the grievance procedure, those circumstances are not present in this case. This ruling does not address whether some other legal or equitable remedy may be available to the grievant in relation to her claims relating to her use of FMLA leave.
[35] *Grievance Procedure Manual* § 7.2(d).
[36] Va. Code § 2.2-3006(B); *Grievance Procedure Manual* § 7.3(a).
[37] *Id.*; *see also* Va. Dep't of State Police v. Barton, 39 Va. App. 439, 445, 573 S.E.2d 319, 322 (2002).