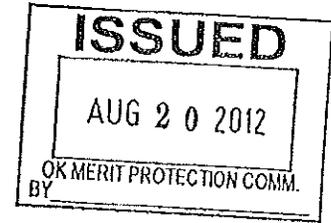


OKLAHOMA MERIT PROTECTION COMMISSION
STATE OF OKLAHOMA



VINCENT SEEMAN,)
)
 APPELLANT,)
)
 v.) MPC-12-151
)
)
 OKLAHOMA DEPARTMENT OF)
 VETERAN AFFAIRS,)
)
 APPELLEE,)

FINAL ORDER

Hearing on this matter was held July 17, 2012, before the duly appointed, undersigned Administrative Law Judge at the offices of the Oklahoma Merit Protection Commission, Oklahoma City, Oklahoma. Present at the hearing was Appellant who was represented by Cathy Talkington. Present for the Oklahoma Department of Veteran Affairs (hereinafter "ODVA" or "Appellee") was Assistant Attorney General Gretchen Zumwalt-Smith. Also present for Appellee was Table Representative Susan McClure.

Appellant was a permanent, classified employee appealing his January 12, 2012, discharge from his employment as a Patient Care Assistant Level 2 working at the Oklahoma Veterans Center in Ardmore, Oklahoma.

Whereupon the hearing began and sworn testimony of witnesses for Appellee and Appellant was presented. In addition, the parties submitted a protective order regarding confidential information which was signed by the undersigned and a joint exhibit book. ¹ Appellee also made a motion to seal the record requesting "the exhibits

¹ Exhibits 1 through 8 and 11 through 16 were admitted at this hearing.

should be forever sealed and not released except upon order by a court of competent jurisdiction.” Appellee’s motion to seal the record was granted.

It is also noted that at the conclusion of the hearing, the parties were given 10 days to submit their written closing statements. On July 26, 2012, Appellee filed an objection to Appellant’s closing statement stating that Appellant referenced exhibits which were not admitted into evidence and made statements which were not part of any testimony at the hearing. The undersigned held the record open an additional 10 days to allow Appellant to respond to Appellee’s objection however no response was filed. Accordingly, Appellee’s objection is sustained and the record is closed August 6, 2012.

After careful consideration of all evidence, testimony, and exhibits, the undersigned Administrative Law Judge issues the following findings of fact, conclusions of law, and order.

FINDINGS OF FACT

On December 18, 2011, Appellant was working the day shift at the Ardmore Veterans Center (hereinafter “the Center”) along with co-worker Patient Care Assistant (“PCA”) Tami Johnston and LPN Abigail Richardson.² PCAs are required when they come on their shifts to do a “compliance round” which is done approximately 30 minutes before the start of the shift. Compliance rounds are also required at the end of the shift. The compliance rounds consist of those workers coming on shift making the rounds to each resident with those going off shift to ensure that any issues, problems or special needs of the residents are called to the attention of the shift coming on duty.

On December 18, Appellant did not do the compliance round when he came on duty because there was limited time to get all the residents out of bed and ready for breakfast. When Appellant went into the room to help get Resident B ready for breakfast, he observed the urine detection band on Resident B’s pull-up which did not show that the pull-up had been exposed to urine.³

² The shifts at the Ardmore Veterans Center are 7am to 3pm, 3pm to 11pm and 11:00pm to 7:00am.

³ The last name of Resident B has been omitted to protect his identity. Only the first initial of Resident Bs last name was used during the hearing.

What Appellant did not do was a complete check of Resident B and the pull-up. Had Appellant done a complete check of Resident B, he would have found that Resident B was wearing two pull-ups which was against policy at the Center. A complete check would require standing Resident B up, pulling his pants down, and checking for wetness; something Appellant admittedly did not do.

Appellant and PCA Johnston then divided the residents into two groups. When there are two PCAs on the floor, the LPN on duty who supervises the PCAs will sometimes break them up and assign different rooms to each of the PCAs. That decision however must be made by the LPN and not the PCAs themselves.

Although PCAs are to check patients every two hours during their shift, Appellant did not see Resident B again until the compliance round at the end of his shift.

At 2:30 Appellant did his compliance rounds with the oncoming shift which consisted of LPN III Terry Bean and PCA Beatrice Wyatt. When Appellant and PCA Wyatt got to Resident B's room, Appellant told PCA Wyatt that Resident B, who was resting in his recliner, had been taken care of by PCA Johnston and there was no need to disturb him. At the end of rounds, Appellant's shift ended and he went home.

Later that afternoon, PCA Wyatt went back to Resident B's room and at that time found him still in his recliner but completely soaked in his own urine with urine dripping from his chair. Upon closer observation, PCA Wyatt found that Resident B had on two pull-ups both of which were soaked with urine. PCA Wyatt then went to Nurse Bean who was her supervisor during that shift and reported Resident B's condition.

Following discovery of Resident B by PCA Wyatt and Nurse Bean, Pamela Arms, Assistant Administrator 1, was put in charge of an investigation of the incident. During the investigation, Assistant Administrator Arms learned that PCA Johnston did not care for Resident B during her shifts because he was a heavy man and she was pregnant.

On December 18, PCA Johnston left the floor at 2:00 and was replaced with PCA Sharikia Roberts. Even though PCA Johnston left the unit at 2:00, Appellant

still had an opportunity to check Resident B during the compliance round at the end of his shift. This did not happen. Assistant Administrator Arms also found that Appellant failed to properly chart information as care was provided to residents.

Regina McCracken is the Administrator of the Center and has worked for the ODVA for 18 years. Upon receipt of the investigative report, a review of the Appellant's disciplinary file, and a pre-termination hearing, Administrator McCracken made the decision to discharge Appellant.⁴

As stated above, Abigail Richardson was the LPN on duty on December 18 during the 7am to 3pm shift and was in charge of Appellant and PCA Johnston during that shift. Nurse Richardson confirmed that PCAs work as a team and as a team they are responsible for every resident on the floor. Nurse Richardson stated that because of prostate complications, Resident B requests trips to the bathroom or his urinal every 5 to 10 minutes and although he urinates frequently, it is always a small amount of output. On that schedule, it was possible for Resident B to remain in a pull-up for up to eight hours.

Both PCA Wyatt, who has been a PCA for 12 years, and Nurse Bean stated that for such a large amount of urine to have soaked through two pull-ups, Resident B would have been in the two pull-ups for some length of time.

It is evident from the testimony of the witnesses at this hearing that conditions at the Center can be stressful and difficult. When Appellant arrived at the Center on December 18, 2011, he had a limited amount of time to get all residents up and ready for breakfast. Appellant and PCA Johnston made the decision, without the direction or instruction by Nurse Richardson, to divide the patients with each PCA taking half the patients. Appellant therefore thought PCA Johnston was caring for Resident B.

Although Appellant understandably relied upon PCA Johnston's assurances to him that she had taken care of her residents and "everything was good", the fact remains that both Appellant and PCA Johnston were responsible for all of the residents on that unit including Resident B.

⁴ Appellant's prior discipline included 3 informal discussions, 2 corrective counseling's, and a verbal warning.

CONCLUSIONS OF LAW

1. The Merit Protection Commission has jurisdiction over the parties and subject matter in the above entitled cause.
2. Any finding of fact which is properly a conclusion of law is incorporated herein as a conclusion of law.
3. OAC 455:10-9-2, **Hearing** states in pertinent part that Appellee has the burden of proof in an adverse action and must prove its case by a preponderance of the evidence.
4. OAC 455:10-11-14, **Causes for discharge, suspension without pay or involuntary demotion** states in pertinent part that any employee in the classified service may be discharged for misconduct, insubordination, inefficiency, inability to perform the duties of the position, willful violation of the Oklahoma Personnel Act or Merit Rules, conduct unbecoming a public employee, or any other just cause.
5. OAC 530:10-11-91, **Conduct of Classified Employees**, states in pertinent part that every classified employee shall fulfill to the best of his or her ability the duties of the office or position conferred upon the employee and shall behave at all times in a manner benefiting the office or position the employee holds and shall devote full time and attention to the duties and responsibilities of his or her position during assigned hours of duty.
6. The ODVA Standard Operating Procedure #713, **Patient Abuse/Neglect** states in part "It is a basic inherent right of every American to live in an environment free of abuse, neglect and exploitation. Each resident residing within one of the Oklahoma State Veterans Centers has actively participated in the promotion or defense of these basic rights".
7. The **Rights and Responsibility Nursing Home Resident Bill of Rights #11** states "Every resident shall have the right to receive courteous and respectful care and treatment." The facility of Ardmore receives funds from the US Department of Veteran Affairs for every war veteran who resides there and in order to receive that funding the Centers employees are required to comply with the rules adopted by the US Department of Veteran Affairs for all state veterans homes.

8. ODVA **Patient Rights and Responsibilities #5** states in pertinent part that every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community.

9. The Appellee has shown by a preponderance of the evidence that just cause existed for the discharge of the Appellant and that discharge was proper. Furthermore, it is the conclusion of the undersigned that the discharge of Appellant did not constitute an abuse in discretion by Appellee under the facts and circumstances of this case.

It is therefore Ordered, Adjudged and Degreed by the undersigned Administrative Law Judge that the appeal of Appellant Vincent Seeman vs. Oklahoma Department of Veteran Affairs, MPC-12-151 be denied.

Signed this 16th day of August, 2012.



P. Kay Floyd, OBA 10300
Administrative Law Judge
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