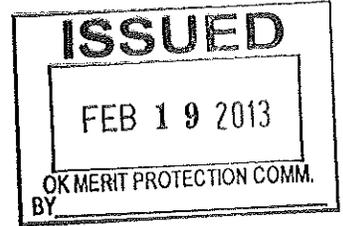


OKLAHOMA MERIT PROTECTION COMMISSION

STATE OF OKLAHOMA



LATRICIA MARTIN and,
JENNIFER GOENS,
Appellants
vs.
OKLAHOMA DEPARTMENT OF
VETERAN AFFAIRS,
Appellee.

CASE NO.: MPC 12-240
MPC 12-241

FINAL ORDER

Hearing on this matter was held before the undersigned duly appointed Administrative Law Judge on January 29, 2013 at the Merit Protection Commission offices in Oklahoma City, Oklahoma. Appellants Latricia Martin and Jennifer Goens, appeared in person and represented themselves. Appellee, Oklahoma Department of Veteran Affairs (hereinafter referred to as "ODVA" or "Appellee"), appeared by and through its Counsel Gretchen Zumwalt-Smith, Assistant Attorney General, and agency representative Susan McClure, Human Resources Director.

Appellants, Latricia Martin and Jennifer Goens, patient care assistants at the Oklahoma Veterans Center in Norman, were suspended without pay for four days for alleged patient neglect for failing to make rounds and provide protection for the residents under their care and for falsification of patient documentation.

Whereupon, the sworn testimony of witnesses for both Appellee and Appellant was presented, along with Exhibits, which were admitted and are incorporated herein and made a part hereof. Accordingly, after 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

Appellant Latricia Martin is a senior patient care assistant (PCA) at the Norman, Oklahoma Veterans Center, where she has worked for nearly 15 years. Appellant Jennifer Goens is a patient care assistant (PCA) who has worked at the Norman Center for six years. On or about March 28, 2012, the two worked together on the 11 pm to 7 am shift on Unit F2. As patient care assistants, their jobs included providing direct and indirect non-professional nursing care to residents, assisting them with their personal needs and daily life activities, and charting their observations of the residents' conditions and activities. (Joint Exhibit 17) Fifty-eight percent (58%) of the 50 residents on F2 unit are Category IV residents, requiring the most intensive nursing care, completely dependent on nursing personnel to provide each aspect of physical care, including bathing, dressing, feeding, elimination, and other supportive care, and may exhibit extreme emotional and/or behavioral patterns of combativeness, ideas of suicide, impulsive behavior, withdrawal, and inability to cooperate or communicate. (Joint Exhibits 18 and 29)

PCA's are required to make rounds to check on residents every two (2) hours, and rounds may normally take an hour to an hour and a half (1-1-1/2 hours) to complete. (Testimony of Appellant Latricia Martin) PCA's begin the 11 pm to 7 am shift assisting PCA's on the prior shift complete their rounds. During their eight hour shift, Appellants are required to perform three rounds, changing residents' incontinence briefs and padding as necessary, turning and repositioning residents in bed, and charting

residents accordingly. These three rounds should begin between 12:30 am and 1:00 am, between 2:30 am and 3:00 am, and between 4:30 am and 5:00 am. Appellant Martin testified that she and Appellant Goens usually begin waking residents on the right side of the unit between 5:00 am and 6:30 am and getting them ready for the day. When the 7 am – 3 pm shift arrives, the PCA's on that shift begin waking residents on the left side of the unit and getting them ready for the day.

On March 30 – 31, 2012, Appellants were running behind on their rounds. One totally disabled resident required more attention than usual, and both Appellants worked for 45 minutes to get the resident onto a lift and settled into bed. (Testimony of Appellants) By their own admission, that night Appellants completed only two rounds instead of three.¹ LPN Lesley McClarty, Appellants' supervisor that night, observed Appellants charting around 3:30 am, but had not seen them performing rounds. She and RN Shannon McCulloch looked in CareTracker, the new on-line charting system, to see what Appellant's were charting. Then the two nurses checked on several of the incontinent residents and found them wet.

On May 8, 2012, April Turner, LPN, notified Administrator Christy Howell that sometime around March 28, 2012 Appellants allegedly falsely documented patient rounds that they had not performed. An investigation was conducted by Administrative Programs Officer II Paula Sexton and Laboratory X-Ray Manager Lee Rhodes. The investigation concluded that the allegation of neglect against Appellants was substantiated, as both Appellants admitted that they only performed two rounds on March 30-31, 2012. (Joint Exhibits 1 and 2) A proposed suspension without pay was

¹ There was some confusion, initially, about the date of the incident. Although the incident occurred at the end of March 2012, it was not reported until May 8, 2012, and the actual date of the occurrence was unclear. Apparently, it was finally settled to have occurred on the 11pm – 7 am shift, March 30-31, 2012.

issued against each Appellant on May 25, 2012, (Joint Exhibits 3 and 4) and a final notice of four-day suspension without pay was issued to each on June 5, 2012. The Notice of Suspension stated:

On May 9, 2012, it was reported that around March 28th you and another PCA allegedly documented patient rounds had been performed when you actually had not performed the rounds. This inaction on your part constitutes neglect in the form of "failure to make rounds" and provide protection for the residents under your care. This was substantiated during an internal investigation

Joint Exhibits 5 and 6

Appellants appealed their discipline, denying that they documented patient rounds that they had not performed, although they admitted that they made only two rounds that evening rather than three.

Administrator Christy Howell stated in the Notice of Suspension to Appellants:

ODVA Standing Operating Procedure #200, Progressive Discipline Policy is a system designed to ensure not only the consistency, impartiality and predictability of discipline, but also the flexibility to vary penalties if justified by aggravating or mitigating conditions. Absent mitigating circumstances is accompanied by a generally automatic progression to the next higher level of discipline...

Joint Exhibits 5 and 6

Appellant Martin's Notice goes on to say:

Due to the nature of this [sic] these infractions and your failure to perform rounds with our residents, *along with documenting in the patient's records that you did*, is just cause for giving adverse action against you in the form of Suspension without Pay, without going through the lower steps of discipline.

(Emphasis added) Joint Exhibit 5

Appellant Martin, who had worked for ODVA for 15 years, had no prior disciplinary actions in her record.

Appellant Goen's Notice cited five prior disciplinary actions in the past three and a half years: one reprimand and four corrective counselings, including a corrective

counseling for “charting things done when they were not done and telling new staff to do it.” (Joint Exhibit 6) Appellant’s Notice stated:

You have previously received several informal counselings and have had a written reprimand; therefore there is just cause for suspension without pay at this time.

Joint Exhibit 6

Although this Administrative Law Judge found no agency policy or other written requirement that PCA’s complete three rounds of residents during a shift², and such rounds are to be made in two hour intervals, testimony of all witnesses, including Appellants, indicates that this is a well-known requirement at the facility. Appellants admit that they performed only two rounds, not three. The internal investigation concluded, as to Appellant Martin:

Conclusion:

The information obtained during this investigation does substantiate the allegation of neglect against Ms. Martin. Residents are to be turned and/or repositioned every two hours. By her own admission Ms Martin states that they only make two rounds a night.

Joint Exhibit 2

As to Appellant Goens, the investigation concluded:

Conclusion:

The information obtained during this investigation does substantiate the allegation of neglect against Ms. Goens. Residents are to be turned and/or repositioned every two hours. By her own admission Ms. Goens states that she “thinks they didn’t do second rounds because they didn’t get started on them until 4:20am.

Joint Exhibit 1

Neither investigation concluded that either Appellant Martin or Appellant Goens falsified the records by charting rounds they failed to perform. In her testimony, Investigator Michelle Sexton indicated that CareTracker reports were not used as the

² This number excludes the round at the beginning of the shift, when assistance is given to the previous shift PCA’s making their rounds, or to the round at the end of the shift when the residents are being awakened and the morning shift PCA’s assist with this round when they arrive.

basis for her findings; that the primary basis of her conclusion was the statements of Appellants themselves.

In fact, the investigation found facility-wide discrepancies in the charting in CareTracker, including charting times that did not match stated sleeping times and activities. There were no records of training on CareTracker, and the investigation report recommended formal training be “provided for all employees that are responsible for Care Tracker documentation.” (Joint Exhibits 1 and 2)

The evidence supports the fact that only a few PCA's received formal training on CareTracker and then were sent back to teach the other PCA's. However, instructions for charting on CareTracker varied and were inconsistent, and many of the PCA's at the facility were confused about how to use it. A review of the Sequential Charting Detail and Charting Detail Report reveals improper charting by other PCA's, such as an entry for resident JB at 12:11 am indicating that he slept seven hours during the 11pm to 7am shift; additionally, most of the charts indicated that the residents were seen only twice on rounds, which is consistent with Appellants' testimony and charting. (Joint Exhibits 14 and 15) The evidence presented does not support a finding that Appellants falsified records to indicate that they performed rounds that they did not perform.

After reviewing the entire record, Appellee has proven, by a preponderance of the evidence, that Appellant Martin and Appellant Goens violated agency policy concerning neglect when they failed to make rounds to check on residents every two (2) hours and failed to notify their supervisor that they were running behind and needed assistance to complete the required three rounds. Appellee has further shown that just cause exists for discipline to be imposed. Appellee has failed to prove by a

preponderance of the evidence that Appellants falsified records to indicate that they performed rounds that they did not perform.

In addition, Appellee has failed to take into consideration mitigating circumstances in determining Appellants' discipline. First, allegations against Appellants were made five weeks after the alleged incident, by an individual who was not on duty or at the facility at the time of the incident and had no direct knowledge, and who did not even know the date of the incident. The two individuals who did have knowledge, had limited knowledge. Both LPN McClarty and RN McCulloch were on other units nearly the entire night. Neither was in a position to observe Appellants making rounds and had no knowledge when or how many rounds were made. LPN McClarty made an assumption when she observed Appellants charting at 3:30 am, that they were charting for their next round at 4:30 am. RN McCulloch did not believe there was sufficient evidence of neglect since "not every resident I checked was found wet" and "it is not unusual to find a resident wet or dirty between rounds." (Joint Exhibit 10) However, neither McClarty nor McCulloch sought information from Appellants concerning their rounds or their charting that evening.

Another point to consider in mitigation was the fact that both Appellants work slowly. It was well known at the facility that both Appellant Martin and Appellant Goens were slow workers. Yet, they were scheduled to work together. If their working slowly had been seen as a problem, supervisors should have placed them each with more efficient PCA's to help improve their efficiency, instead of placing them with each other.

An important mitigation point for Appellant Martin is the fact that she admitted that she only made two rounds instead of three and didn't try to hide that fact. Additionally, Appellant Martin has worked at the Norman facility nearly 15 years and

never received any prior disciplinary actions. Yet she received the same discipline as Appellant Goens, who had five prior disciplines in the past three and a half years.

CONCLUSIONS OF LAW

1. The Oklahoma Merit Protection Commission has jurisdiction over the parties and subject matter in the above-entitled matter.

2. Any findings of fact that are properly conclusions of law are so incorporated herein as conclusions of law.

3. Merit Rule 455:10-11-14 states that a permanent classified employee may be suspended without pay not to exceed sixty calendar days for misconduct, inefficiency, willful violation of the Oklahoma Personnel Act and Merit Rules, conduct unbecoming a public employee, and any other just cause.

4. Merit Rule 455:10-9-2(f)(1) states that the Appellee bears the burden of proof in an adverse action and must prove by a preponderance of the evidence that just cause exists for adverse action and that the discipline imposed was just.

5. ODVA SOP #713, **Patient Abuse/Neglect**, *Summary of Policy*, states that 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.

6. ODVA SOP #713, **Patient Abuse/Neglect**, *Definitions*, defines Neglect as a lack of proper care or attention in the performance of assigned duties. This includes the failure to provide protection for a vulnerable adult with shelter, nutrition, health care,

or clothing, or negligent acts or omissions that result in harm or the unreasonable risk of harm to the resident through the action, inaction, or lack of supervision by a caretaker.

7. ODVA SOP #713, **Patient Abuse/Neglect**, *Protection of Alleged Victims of Abuse*, requires the Administrator or designee to take immediate action to protect the resident from harm when abuse is suspected or reported.

10. Appellee, Oklahoma Department of Veterans Affairs, has met its burden to prove, by a preponderance of the evidence, that just cause exists to discipline Appellant Latricia Martin and Appellant Jennifer Goens when they failed to complete three rounds with residents and failed to notify their supervisor that they were running behind and needed assistance to complete their rounds timely.

11. Appellee, Oklahoma Department of Veterans Affairs, has failed to meet its burden to prove, by a preponderance of the evidence, that Appellant Martin and Appellant Goens falsified records by documenting in patient's records that they had performed rounds they had not performed; and failed to prove, by a preponderance of the evidence, that the discipline imposed – four-day suspension without pay – was just under the circumstances.

ORDER

IT IS THEREFORE ORDERED, ADJUDGED, AND DECREED by the undersigned Administrative Law Judge that the petitions of Appellant Latricia Martin and Appellant Jennifer Goens are hereby **GRANTED IN PART**. Appellant Goens' discipline is hereby reduced from a four-day suspension without pay to a three-day suspension without pay. Appellant Martin's discipline is hereby reduced from a four-day suspension without pay to a letter of reprimand.

Appellee Oklahoma Department of Veteran Affairs is directed to rescind the subject discipline and reissue the discipline in accordance with this Order; to purge the files of Appellant Martin and Appellant Goens of any reference to improper documenting in patients' records; and to reinstate Appellants with back pay and benefits in accordance with this Order.

All actions directed under this Order shall be executed in full within twenty (20) days of the date of this Order.

DATED: this 15th day of February, 2013.



Annita M. Bridges, OBA # 1119
Administrative Law Judge
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