SUSAN PRESTON,

Grievant,

v.

DOCKET NO. 97-VA-503

DIVISION OF VETERAN AFFAIRS,

Respondent.

D E C I S I O N

This grievance was submitted by Grievant Susan Preston directly to Level IV, pursuant to W. Va. Code § 29-6A-4(e), on November 17, 1997, after she was dismissed from her employment with Respondent Division of Veterans Affairs ("VA"), on November 13, 1997, for gross misconduct. Grievant sought as relief to be made whole. A Level IV hearing was held on January 22 and February 4, 1998, and this matter became mature for decision upon receipt of the parties' final written argument on February 26, 1998.

SUMMARY OF EVIDENCE

Respondent's Exhibits

Ex. 1 -

November 12, 1997 dismissal letter from G. L. Harper to Susan Preston.

Ex. 2 -

West Virginia State Board of Examiners for Licensed Practical Nurses, Laws and Rules, effective June 1, 1997.

Ex. 3 -

West Virginia State Board of Examiners for Licensed Practical Nurses, Manual of Recommendations and Requirements for Education and Licensure, effective April 16, 1992.

Ex. 4 -

West Virginia Veterans Home Nursing Manual, revised October 1997.

Ex. 5 -

August 2 and 4, 1997, Incident Report by Louise McMullen.

Ex. 6 -

Fire Alarm Panel Printout, July 29 - August 2, 1997.

Ex. 7 -

September 21, 1997 handwritten memorandum from Pat Ramey to Louise McMullen.Ex. 8 -
Handwritten note received by Louise McMullen on August 14, 1997.

Ex. 9 -

September 21, 1997 Incident Report by Betty McNeely.

Ex. 10 -

December 3, 1997 Incident Report by Pat Ramey

Ex. 11 -

October 22, 1997 memorandum from Pat Ramey to Louise McMullen.

Ex. 12 -

October 23, 1997 memorandum from Louise McMullen to Susan Preston.

Ex. 13 -

October 24, 1997 Incident Report by Susan Preston.

Ex. 14 -

West Virginia Veterans Home 24 Hour Nurses Report, October 22, 1997.

Ex. 15 -

West Virginia Veterans Home 24 Hour Nurses Report, October 23, 1997.

Ex. 16 -

October 24, 1997 Incident Report by Pat Ramey.

Ex. 17 -

Discarded Medications List, October 22 - November 3, 1997.

Ex. 18 -

October 30, 1997 Incident Report by Pat Ramey, with Nurse Medication Record and Notes attached.

Ex. 19 -

November 12, 1997 Incident Report by Pat Ramey.

Ex. 20 -

October 31, 1997 letter from Robert Walker, M.D. to Louise McMullen.

Ex. 21 -

West Virginia Veterans Home Employee Handbook.

Ex. 22 -

West Virginia Veterans Home Residents Handbook.

Ex. 23 -

West Virginia Division of Personnel Drug-Free Workplace Policy.

Ex. 24 -

Employee Drug Awareness Certification Form, signed by Susan Preston on March 24, 1992.

Ex. 25 -

Order Sheet, September 9, 1997.

Ex. 26 -

Order Sheet, November 10, 1997.

Ex. 27 -

September 29, 1997 Notes of Staff Meeting.

Ex. 28 -

October 30, 1997 letter from Patricia Ramey to Registered Professional Nursing Board.

Ex. 29 -

September 9, 1997 letter from LPN Staff to Registered Professional Nursing Board.

Ex. 30 -

Curriculum Vitae of Mary Rebecca McVey.

Ex. 31 -

February 2, 1998 letter from Melanie Lawson to Stephanie M. Sisson.

Grievant's Exhibits

Ex. 1 -

July 28, 1997 memorandum from LPN Staff to Melani (sic) Lawson.

Ex. 2 -

Resident Log Sheet for D.W.

Ex. 3 -

Fire Alarm Panel Printout for July 8-9, 1997.

Ex. 4 -

May 23, 1997 medication order from Robert Walker, M.D. to Louise McMullen.

Ex. 5 -

August 21, 1997 letter to Gail Harper from Pat Ramey.

Ex. 6 -

Discarded Medications List, August 5 - 18, 1997.

Ex. 7 -

Monthly Time and Attendance Report, September 1 - 30, 1997, for Susan Preston.

Testimony

Respondent offered the testimony of Louise McMullen, Jack Sells, Frederick Hubbard, Gail Harper, Pat Ramey, Betty McNeely, Kathy Charlton, Kelly Hite, and Rebecca McVey. Grievant testified in her own behalf.

Discussion

The burden of proof in disciplinary matters rests with the employer, and the employer must meet that burden by proving the charges against an employee by a preponderance of the evidence. W. Va. Code § 29-6A-6; Ramey v. W. Va. Dept. of Health, Docket No. H-88-005 (Dec. 6, 1988). "The preponderance standard generally requires proof that a reasonable person would accept as sufficient that a contested fact is more likely true than not." Leichliter v. W. Va. Dept. of Health and Human Resources, Docket No. 92-HHR-486 (May 17, 1993). Where the evidence equally supports both sides, the employer has not met its burden. Id.

The employer must also demonstrate that misconduct which forms the basis for the dismissal of a tenured state employee is of a "substantial nature directly affecting rights and interests of the public." House v. Civil Service Comm'n., 181 W. Va. 49, 380 S.E.2d 226 (1989). "The judicial standard in West Virginia requires that `dismissal of a civil service employee be for good cause, which means misconduct of a substantial nature directly affecting rights and interests of the public, rather than upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention.' Syl. Pt. 2, Buskirk v. Civil Service Comm'n, 332 S.E.2d 579, 581 (W. Va. 1985); Oakes v. W. Va. Dept. of Finance and Admin., 264 S.E.2d 151 (W. Va. 1980); Guine v. Civil Service Comm'n, 141 S.E.2d 364 (W. Va. 1965)." Scragg v. Bd. of Dir. W. Va. State College, Docket No. 93-BOD-436 (Dec. 30, 1994). Prior to her dismissal, Grievant was employed at the Veterans Home in Barboursville as a Licensed Practical Nurse ("LPN"). The Veterans Home is a residence care facility which houses approximately 68 disabled veterans, more than 90% of whom are emotionally disturbed or have a substance abuse problem. The Veterans Home provides no medical treatment, but the nurses maintain certain medical records, dispense prescribed medicine to some residents, take

blood pressure readings, and give injections.

Grievant's supervisor was Louise McMullen, a Registered Nurse and Director I, Nursing Services, at the Veterans Home. Ms. McMullen directs the nursing department, makes its policies and procedures, carries out Division of Personnel policies and procedures, the Home's policies and procedures, federal rules and regulations applicable to the Veterans Home, and nursing licensure laws. Her staff consists of five LPN's, two health service workers, and one other RN. Spurlock v. Division of Veterans Affairs, Docket No. 97-VA-504 (Feb. 27, 1998).

Grievant's dismissal letter recites that Grievant was dismissed for:

> gross misconduct, that is, your repeated violation of the professional conduct and ethics standards expected of a Licensed Practical Nurse; your repeated efforts to disrupt the effective and efficient operation of the Nursing Department which has resulted in the creation of a highly negative and hostile working environment, and your repeated violation of the operating policies and procedures of the Nursing Department, . . . [Y]our misconduct demonstrates a willful disregard of the standards of behavior your employer has the right to expect from its employees.

The dismissal letter goes on to recite eight “specific reasons” in support of the charges, which will be addressed separately. After some of the charges is a citation to one or more sections of the West Virginia State Board of Examiners' “Law and Rules” for LicensedPractical Nurses, dated June 1, 1997. The sections are 10.2.12.1.5.12, 10.2.12.1.5.21 (See footnote 1) , 10.2.12.1.5.23 (See footnote 2) and 10.2.12.1.5.27. (See footnote 3) These sections state four of the many actions or conditions which may result in the Board of Examiners taking disciplinary action against a licensee. No evidence was presented that Grievant was reported to the Board of Examiners. Section 10.2.12.1.5.12 states, “failing to follow established policies and procedures in the practice setting to safeguard patient care.” Section 10.2.12.1.5.21 states, “falsifying patient records or intentionally charting incorrectly.” Section 10.2.12.1.5.23 states, “failing to conform to standards of nursing practice as defined in 10 CSR 3, Standards of Nursing Practice for the Licensed Practical Nurse”. Section 10.2.12.1.5.27 states, “other acts, which in the opinion of the Board, constitute professional misconduct.” (Emphasis added).

The specific incidents which formed the basis of the decision to dismiss Grievant follow.

A.

LEAVING WORK AREA ON PERSONAL BUSINESS WITHOUT AUTHORIZATION.

The dismissal letter recites this incident as:

> On July 9, 1997, you left your work area, on the ground floor of Building C, without authorization, to socialize with a resident of the Veterans Home (Resident D.W.). When found outside your work area, coming down the ramp from Building B, by your immediate supervisor, Mrs. Louise McMullen, R.N., Director of Nursing, you told Mrs. McMullen that you had to leave your work area in response to a fire alarm, when in fact, the fire alarm record reveals that no such fire alarm sounded at that time. In addition, when Mrs. McMullen asked two residents who were present in that area at that time if anything unusual had happened, they responded by saying that nothing had. Leaving your work area on personal business during work hours without authorization is contrary to Nursing Department policies and procedures and standards of nursing practice for Licensed Practical Nurses (Ref. 12.1.5.12 and 12.1.5.22).

The original November 12, 1997, dismissal letter, was later amended in several significant particulars. With regard to this first charge, the date “July 9, 1997" was changed to “August 2, 1997.” The reference to resident “D.W.” was changed to resident “T.S.”

Ms. McMullen testified that on August 2, 1997, she was approaching the “C” Building of the Veterans Home, when she saw Grievant on the landing between “C” Building and “B” Building. Upon entering the “C” Building, there is a landing, with steps going down to the basement, or up to the first floor. The nurses' station is in the basement of the “C” Building. To the left of the landing are fire doors leading to the elevator for “C” Building. Past the elevator is a ramp which goes into the “B” Building, a residence building. Ms. McMullen saw Grievant on the landing where the stairs lead down to the basement. (See footnote 4) She asked Grievant what she was doing out of her work area, and Grievant stated she was responding to a fire alarm panel light. Ms. McMullen saw tworesidents standing in the hallway and asked them if anything unusual had happened, and they responded only that they just saw the nurse coming off the elevator. Ms. McMullen then checked the fire alarm panel, and there was no indication of a fire alarm on August 2, 1997. She followed up on this matter on Monday, August 4, 1997, when she asked Mr. Elkins, a maintenance department employee, to check the printout for the fire alarm panel for August 2, 1997, to see if it showed any alarm. He stated that the printout did not show any alarm. R. Ex. 6. Ms. McMullen filled out an incident report on this matter on August 4, 1997. R. Ex. 5. (See footnote 5)

Grievant denies she was away from her work station on August 2, 1997. Grievant testified that she did respond to a fire alarm panel light on July 9, 1997, the date referenced in the original dismissal letter as the date of the incident comprising Charge 1 against her. A printout of the fire

alarm panel for July 9, 1997, indicates there was trouble with the fire alarm panel on that day. G. Ex. 3. Interestingly, on the copy of the printout for July 9, 1997, handwritten notations indicate “misconduct” and references to sections 12.1.5.22 and 12.1.5.12, two of the standards of conduct which Grievant is alleged to have violated. The original dismissal letter also references that Grievant “fraternized” with resident “D.W”. However, it was proven by Grievant that resident “D.W.” was not even on the premises ofthe Veterans Home on July 9, 1997. Ms. McMullen later testified that it was supposed to read resident “T.S.”

Quite, frankly, I am unable to make any findings from the recitation of events described which comprise this charge. It is simply too unclear what exactly happened on what date. I find it highly suspect that, despite Respondent's assertion that the dismissal letter contained typographical errors with respect to the date and the resident involved in this incident, that when Ms. McMullen read Grievant the dismissal letter, she did not bother to mention that the date and resident were incorrect at the time. As far as Grievant was concerned, she was being disciplined for an incident that happened on July 9, 1997. In addition, Ms. McMullen did not speak to Grievant about this incident contemporaneously with its occurrence, nor did she take any steps to discipline her at the time. If Grievant's alleged violation of leaving her work station was so severe as to warrant discipline, it should have been brought to her attention when it happened, not five months later in a dismissal letter.

Because the Respondent has the burden of proving the charges against Grievant by a preponderance of the evidence, which means it is more likely than not that the events occurred as Respondent alleges, I must conclude that Respondent has failed to substantiate this charge.

B.

INAPPROPRIATE COMMENTS REGARDING USE OF ALCOHOL AND ILLEGAL DRUGS.

The dismissal letter recites this incident as:

> On September 19, 1997, you had made several highly inappropriate comments regarding your use of alcohol and illegal drugs. You made comments to a coworker about getting drunk after work and removing illegal drugs from your car. You also asked a coworker to go to your house and“burn one”, clearly referencing the smoking of marijuana. Such comments (even if intended as a jokes (sic)) are highly inappropriate and unprofessional and have no place in the workplace.

This was brought to the attention of Ms. McMullen by Pat Ramey, a fellow LPN, in a handwritten letter dated September 21, 1997. Ms. Ramey stated in her letter that she was concerned about Grievant's behavior and possible alcohol and drug abuse. She said she observed mood swings, from “throwing of insulin bottles, profanity and slamming of refrigerator doors to singing and laughing inappropriately.” She also indicated that Grievant told a coworker she was going to “get drunk” after work, and that drugs had been ordered for a party. R. Ex. 7.

Ms. McMullen testified a resident slipped a note under her door on August 14, 1997, which says, “Check your nurses for pot and drug use.” (Emphasis in original). R. Ex. 8. There is nothing on this note that references Grievant. On September 21, 1997, Ms. McMullen received an incident report from LPN Betty McNeely, stating she was concerned about drug use in the facility, and rumours about drug use in the nursing department. No names are mentioned in this incident report. R. Ex. 9. Ms. McNeely testified she was referring to Grievant in the incident report because she had heard rumours about her. LIV Trans., Vol. II, p. 95. Finally, on December 3, 1997, Pat Ramey submitted an incident report reporting a rumor that Grievant had sold marijuana to a resident, which she had heard back in September 1997. R. Ex. 10.

Ms. McMullen testified she was very concerned with Grievant's behavior and possible drug and/or alcohol abuse. Nevertheless, despite these concerns, Ms. McMullen never talked to Grievant specifically about her concerns of drug or alcohol abuse. Rather, Ms. McMullen told Grievant once in September 1997, that she had heard she was laughinginappropriately, and asked her if she needed help. LIV Trans., Vol. 1, p. 117; LIV Trans., Vol. II p. 215.

Ms. McMullen also testified that Grievant's performance had been very poor. However, no evidence was presented in the form of performance evaluations to demonstrate that Grievant's performance as an LPN was overall very poor. Neither had Grievant been the subject of any discipline in the twelve months preceding her dismissal. LIV Trans., Vol. II, p. 160.

While Ms. McMullen may have been genuinely concerned about Grievant in this regard, her failure to speak to Grievant or to get her some assistance or help for her suspected problems, tends to discredit Ms. McMullen's serious concern regarding Grievant's behavior or performance. There was no direct proof that Grievant engaged in drug or alcohol abuse, and there is nothing in the dismissal letter to indicate Grievant was dismissed for alcohol or drug abuse. Rather, the incident

referred to above merely cites that Grievant made inappropriate jokes about alcohol and drugs. Grievant admits making jokes, and Ms. McMullen testified that after she talked to Grievant about her laughter in September, she never heard anything more about Grievant laughing and joking. LIV Trans., Vol. I, p. 117.

Joking about alcohol and drugs is a far cry from abusing them. Respondent attempted over and over again to introduce testimony and evidence regarding Grievant's drug and alcohol abuse, which the undersigned ruled inadmissible. It is patently unfair, and a serious deprivation of due process, to try to establish proof of allegations which were not included in Grievant's dismissal letter. If Respondent wanted to dismiss Grievant for drug and alcohol abuse, then it should have done so. Standing alone, joking or “laughinginappropriately” is not a grounds for dismissal of an employee. Indeed, the only testimony regarding laughing inappropriately was rendered by Betty McNeely, who stated that Grievant sometimes laughed at her jokes, which weren't that funny, and therefore, she concluded Grievant was laughing “inappropriately.” LIV Trans., Vol. II, p. 97. Respondent has simply failed to substantiate this charge as grounds for dismissal.

C.

ATTEMPT TO USE MS. MCMULLEN AS A SCAPEGOAT FOR THE ALLEGED MISDEED OF A COWORKER.

The dismissal letter recites this incident as:

> On October 22, 1997, one of your coworkers reported to Mrs. Louise McMullen, Director of Nursing, that you had written a letter to the Board of Examiners for Licenses Practical Nurses regarding a complaint made to the Board which charged your coworker with altering a medical record. In your letter, which was to be signed by your coworker and sent to the Board as though she had written it, you proposed that your coworker states that she altered the medical record in question out of fear for Mrs. McMullen, R.N. Your attempt to use Mrs. McMullen as a scapegoat for the alleged misdeed of one of your coworkers is totally unprofessional, unethical and serves only to further create a hostile and negative work environment which cannot be tolerated.

The background for this charge stems from an incident which occurred in May 1997. On May 23, 1997, Dr. Robert Walker faxed a medication order to Ms. McMullen for resident E.H. Upon receipt of the order, Ms. McMullen allegedly instructed Pat Ramey, an LPN, to cut off the top of the fax, including the date and time of the transmittal, and to pencil in an earlier date on the order. In

essence, Ms. McMullen instructed Pat Ramey to backdate the medication order. Grievant was present when Ms. Ramey was cutting off the top of the fax. Ms. Ramey told Grievant that she was following Ms. McMullen's instructions. Grievant believed Ms. McMullen's instructions to Ms. Ramey to alter the medication order wereinappropriate and, along with other nurses, took steps to report the conduct to the Registered Professional Nursing Board ("RN Board").

During the investigation by the RN Board into this complaint, another LPN, Kathy Spurlock, also reported Pat Ramey to the LPN Board for the same incident. Grievant called Ms. Ramey at work and told her she was sorry she had been reported, and had drafted a letter in support of her, stating she believed Ms. Ramey followed Ms. McMullen's instructions out of fear. Ms. Ramey told Grievant not to send the letter in her behalf to the LPN Board, and Grievant honored Ms. Ramey's wishes. She did not send the letter. However, Ms. Ramey reported to Ms. McMullen on October 22, 1997, that Grievant had offered to write the letter in her support. R. Ex. 11. On that memorandum, Ms. McMullen wrote "offered to write 'I'll write & say you did it because you were afraid of Louise", and also noted "continuing hostile behavior", with reference to Grievant. R. Ex. 11.

Ms. Ramey testified she told Mr. Hubbard, Administrator of the Veterans Home, in an August 1997 meeting, that Ms. McMullen told her to backdate the order. She also told him she was "concerned" about how this might affect her job, and was worried about retaliation. Grievant was present at this meeting. Ms. Ramey also wrote a letter to Gail Harper, Director of Veterans Affairs, expressing her fears about Ms. McMullen, in that she had told Ms. Ramey she was going to sue everyone involved with the charge against her, and that she was going to recommend that all the LPN's be replaced by RN's. G. Ex. 5. LIV Trans., Vol. II, pp. 28-30.

It is clear the allegations in this charge against Grievant simply did not occur as stated. There was no evidence to support the allegation that Grievant had written the letter for Ms. Ramey to sign as though she had written it. Grievant and Ms. Ramey testified thatGrievant intended to send the letter under her own signature on Ms. Ramey's behalf. There was no evidence to refute that Grievant had anything but a good faith belief that Ms. Ramey had acted out of fear of Ms. McMullen in altering the medication record, and wished to convey that to the LPN Board. However, no letter was ever sent by Grievant, because Ms. Ramey asked her not to send it. The conclusion in this allegation that Grievant was attempting to "use Ms. McMullen as a scapegoat for the alleged misdeed of one of [her] coworkers" simply is not substantiated by any evidence. Respondent pointed to no rule, regulation or

practice which would prohibit an LPN from offering assistance or pertinent information in an investigation of a coworker for alleged wrongdoing. It appears Grievant was disciplined for this conduct merely because she was willing to support Ms. Ramey vis- a-vis Ms. McMullen with regard to this incident. Respondent has failed to prove by a preponderance of the evidence that this conduct constitutes misconduct, much less “gross misconduct”, deserving of dismissal from employment.

D.

WEARING A UNION PIN.

The dismissal letter recites this incident as:

> On October 22, 1997, you were observed by Mrs. Louise McMullen, R.N., wearing a union pin while on duty in the nurses station, which is in direct violation of the Veterans Home's Employees Handbook which states that, “other clips, badges, buttons and insignias are not to be worn or displayed at any time while on duty unless authorized by Administration.” When asked by Mrs. McMullen, R.N., if you had secured such authorization, you responded that you had not. The act of wearing your union pin in clear violation of the Home's policy further demonstrates your efforts to create a hostile working environment and conflict between line staff and your immediate supervisor and is contrary to the behavior expected of a Licensed Practical Nurse.

Grievant admitted she wore her union pin on the stated date. She testified she was not aware of any policies against wearing pins, and when Ms. McMullen instructed her bymemorandum not to wear the pin, and gave her a copy of the policy, Grievant removed the pin and never wore it again. Grievant told Ms. McMullen she did not want a reprimand placed in her personnel file because of her innocent violation of the policy, and told her she might file a grievance over that issue. LIV Trans., Vol. II, p. 188. Ms. McMullen testified that Grievant created a hostile working environment when she “threatened” to file a grievance over the written reprimand. LIV Trans., Vol. II, p. 243. Ms. McMullen also testified this charge would not support dismissal from employment from the Veterans Home. While Respondent has proven that this incident did occur, it has not proven that it was worthy of dismissal from employment.

E.

UNACCEPTABLE JOB PERFORMANCE AND NEGLIGENT NURSING CARE FOR FAILING TO REPORT A PROBLEM WITH RESIDENT M.H.'S MEDICATION.

The dismissal letter recites this charge as:

> On October 22, 1997, Resident M.H.'s prescription medicine (Darvon) did not arrive as scheduled from the Veterans Administration Pharmacy. As per nursing procedure, you checked on the status of the resident's medication. However, the medicine never arrived and you did not bring the problem to the attention of Mrs. Louise McMullen, the Director of Nursing until October 24, 1997. Your failure to follow up on the situation, for whatever reason, by reporting it to your immediate supervisor is an example of totally unacceptable job performance and negligent nursing care. Such a problem should have been brought to your supervisor's attention immediately. You should not have waited until the situation became serious before you acted in clear violation of nursing standards (Ref. 12.1.5.12).

This incident arose from the failure of the Veteran's Administration to send over prescribed medications for resident M.H. Grievant testified that, when the medicines did not arrive for Resident M.H. as scheduled, she verbally told Ms. McMullen, who told her to call the VA Hospital. LIV Trans., Vol. II, p. 189. She called the VA Hospital three or four times to inquire about the medicines. Each time, following procedure and protocol,Grievant recorded her inquiries and the VA's response on the Veterans Home 24-hour report sheets. R. Exs. 13, 14. The purpose of these reports is to advise the nursing staff of the events and problems, if any, of each day. During the hearing, Ms. McMullen identified these reports and acknowledged Grievant's entries thereon. Ms. McMullen also testified that she knew M.H.'s medications had not arrived. LIV Trans., Vol. I, p. 136.

Apparently, what triggered this charge against Grievant was the fact that M.H. complained to Frederick Hubbard and Gail Harper about his medications. They, in turn, confronted Ms. McMullen, wondering what the problem was with M.H.'s medication. Ms. McMullen clearly was not happy being confronted by her superiors in this manner. Indeed, she testified her complaint with Grievant was not that she did not report the problems with the medications, but that she did not tell Ms. McMullen that M.H. was becoming agitated and upset. LIV Trans., Vol. I, p. 134. Grievant testified M.H. had not voiced his complaints to her. LIV Trans., Vol. II, p. 189. Ms. McMullen instructed Grievant to fill out an incident report about this matter, which she did, on October 24, 1997. R. Ex. 13. No disciplinary action was taken against, or discussed with, Grievant following this incident.

It clearly was not Grievant's fault that M.H.'s medications were not sent to the Veterans Home by the VA Hospital. Nonetheless, it appears Grievant did everything a reasonable nurse in her position could have done. Yet, her termination letter describes her actions as “totally unacceptable job performance and negligent nursing care.” Again, if Grievant's conduct was so gross, she should have

been counseled about it when it occurred. The evidence presented regarding this incident does not support the charge against Grievant. **F.**

WILLFULLY VIOLATING NURSING PROTOCOL FOR DISPOSING OF CONTROLLED DRUGS.

The dismissal letter recites this charge as:

> On October 23, 1997, you willfully violated the Nursing Department's protocol for disposing of controlled drugs, prescribed for Resident T.R., by not having another nurse present to witness the fact that each and every dose of medicine was actually destroyed. This is in clear violation of Nursing Department practices and procedures and nursing standards (Ref. 12.1.5.12 and 12.1.5.19).

Once again, this is a charge which sounds very serious, and yet, simply did not occur as stated in this dismissal letter. On October 23, 1997, the date in question, Grievant and Kathy Charlton, a contract LPN, went into the restroom to dispose of 6 Tylenols prescribed to resident T.R. Ms. Charlton was present with Grievant from the time Grievant counted the medications to be disposed, up to and through the actual disposal. At the end of this routine, Ms. Charlton initialed the medical discard sheet, signifying the disposal had been conducted properly. R. Ex. 17. Moreover, Ms. Charlton testified she did not believe there were any problems with the disposal routine that day. LIV Trans., Vol. II, pp. 116- 120.

Notably, the incident report upon which this allegation is based was written and signed by Pat Ramey. R. Ex. 16. Both Grievant and Ms. Charlton testified Ms. Ramey was not even present during the disposal process in question. Further, Ms. Ramey testified that on August 13, 1997, three months prior to the “incident” alleged in the dismissal letter, Grievant violated the same protocol. Specifically, Ms. Ramey testified she was the witnessing nurse for the disposal, and that when she left the room for a moment, Grievant completed the disposal without Ms. Ramey being present. However, Respondent could produce no contemporaneous incident reports or other notes regarding this allegedmisconduct. In fact, on August 13, 1997, Ms. Ramey initialed the medical discard sheet relevant to this event. G. Ex. 6.

This appears to be yet another example of Respondent struggling to create misconduct on the part of Grievant, when there was none. Even bootstrapping the August 13 “incident” to this allegation, Respondent did not prove any wrongoing, or “willful violation” of any nursing protocol on the part of

Grievant.

G.

FAILURE TO PROPERLY TRANSCRIBE A PHYSICIAN'S ORDER FOR MEDICATION FOR RESIDENT M.S.

The dismissal letter recites this charge as:

> On October 30, 1997, it was discovered that you had failed to properly transcribe a physician's order for medication for Resident M.S., in the Medication Administration Record, which resulted in the patient/resident receiving the incorrect dosage of medication. Such an error reflects poor job performance and is contrary to established nursing practice (Ref. 12.1.5.1).

This charge actually relates to two separate incidents, and once again, these charges are fictitious. Resident M.S. routinely left the Veteran's Home in the morning, and did not return until the evening. His prescription orders are for one Percocet tablet every 6 hours, p.r.n., or as needed. The evidence established that there was a routine, followed by the nursing staff, of giving M.S. two pills when he left the Veterans Home for the day. This dosage was consistent with his order for one pill every six hours.

On November 12, 1997, Grievant, following the usual procedure, gave M.S. two Percocet tablets in the morning. She charted that she gave him two tablets at 7:20 a.m., rather than charting one tablet at 7:20 a.m., and the second as a self-medication six hours later. If an error was committed, it was the error of not separately noting each pill on the records. In other words, if there was an error, it was a transcription error, not a dosageerror. M.S. did not receive an incorrect dosage of his medication as alleged in the charge against Grievant.

As to the allegation of improperly transcribing a physician's order, Respondent attempted to obscure the facts by producing an array of documents in an effort to create some appearance of a mistake by Grievant. Allegedly, Grievant made an error when she was transcribing a physician's order onto a resident's medical chart. This mistake in charting allegedly occurred in September 1997. Ms. Pat Ramey, when creating the charts for October, copied the order from the September chart to the October chart. Subsequently, Ms. McMullen caught the error and changed the chart on October 8, 1997. She spoke to all of the nurses that day about the importance of charting and being cautious in transcribing orders. LIV Trans., Vol. I, pp. 152. Ms. Ramey later saw the changed notation on the

chart, and asked Ms. McMullen about it. Ms. McMullen told her there had been a mistake in charting, and that she had corrected it. Ms. Ramey filled out an incident report on this matter on October 30, 1997. R. Ex. 18.

Ms. McMullen testified she had a document from which she determined that it was Grievant who had improperly transcribed the physician's order sometime in September 1997. However, although Respondent produced numerous records which were purportedly relevant to these allegations, Respondent failed to produce the one document which supposedly proved that Grievant had improperly transcribed the physician's orders. In the end, Respondent proved nothing other than a charting error had been made, Ms. McMullen caught it, and, she had counseled all of the nurses to be more careful in their charting. There was no evidence that Ms. McMullen ever spoke to Grievant about this mistake, or disciplined her in any way prior to the dismissal letter. Again, if this was such a seriouserror on Grievant's part, Ms. McMullen should have spoken to her about when she discovered the mistake on October 8, 1997.

Respondent presented expert testimony from Rebecca McVey, R.N., in order to justify Grievant's termination. However, Respondent's own expert admitted that, in forming her opinion, she relied solely on the termination letter, and assumed all of the charges made against Grievant were true. Ms. McVey testified that her opinion regarding the propriety of Grievant's termination would change if the charges were false. LIV Trans., Vol. II, pp. 145-156.

Further, Jack Sells, the Division of Personnel representative who drafted the dismissal letter, testified that he, too, assumed the information he received from Ms. McMullen was true, and relied solely on her representations of the events described in the letter. Mr. Hubbard and Mr. Harper also relied solely on Ms. McMullen's representations, and both testified their opinions of Grievant's termination would change if the charges were false. All of these gentlemen stressed that, when the decision to terminate Grievant was made, they were concerned about possible retaliation because they knew the nurses had filed a complaint against Ms. McMullen with the RN Board. They apparently were convinced there was no retaliatory motive behind Ms. McMullen's recommendation to terminate Grievant.

H.

RETALIATION

Grievant alleges that Ms. McMullen recommended her dismissal in reprisal for her participation in

filing a complaint against her with the RN Board for various incidents, or more precisely, her "whistle-blowing" activities. Allegations of unlawful retaliation under the "Whistle-Blower Law", W. Va. Code §§ 6C-1-3 are properly within the jurisdiction of theWest Virginia Education and State Employees Grievance Board. Barber v. Div. of Highways, Docket No. 94-H-267 (Feb. 28, 1995); Coddington v. W. Va. Dept. of Health and Human Resources, Docket Nos. 93-HHR-265, 266, 267 (May 19, 1994); Graley v. W. Va. Parkways Economic Dev. & Tourism Auth., Docket No. 91-PEDTA-225 (Dec. 23, 1991).

W. Va. Code § 6C-1-3 provides that:

> (a) No employer may discharge, threaten or otherwise discriminate or retaliate against an employee by changing the employee's compensation, terms, conditions, location or privileges of employment because the employee, acting on his own volition, or a person acting on behalf of or under the direction of the employee, makes a good faith report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste. . . .

Code § 6C-1-4 provides that:

> (a) A person who alleges that he is a victim of a violation of this article may bring a civil action in a court of competent jurisdiction for appropriate injunctive relief or damages, or both, within one hundred eighty days after the occurrence of the alleged violation.
>
> (b) An employee alleging a violation of this article must show by a preponderance of the evidence that, prior to the alleged reprisal, the employee, or a person acting on behalf of or under the direction of the employee, had reported or was about to report in good faith, verbally or in writing, an instance of wrongdoing or waste to the employer or an appropriate authority.
>
> (c) It shall be a defense to an action under this section if the defendant proves by a preponderance of the evidence that the action complained of occurred for separate and legitimate reasons, which are not merely pretexts. . . .

See also, Barber v. Div. of Highways, Docket No. 94-H-267 (Feb. 28, 1995).

There is no dispute that Grievant, prior to the alleged reprisal, i.e., her dismissal, reported instances of wrongdoing or waste to the employer or appropriate authorities. In 1997, Grievant was one of five nurses who, together, made one or more complaints to the RN Board about the conduct of Ms. McMullen. One complaint was prompted by anincident involving resident T.S. In early July 1997, resident T.S. was discharged from the Veterans Home. Just prior to leaving the home, he requested his medications. He was told by Ms. McMullen that she did not have his medications. T.S.

left the home, after some protest. Shortly thereafter, Ms. McMullen called Grievant and another LPN, Kathy Spurlock, into her office. She produced a brown paper bag which contained various prescription medications belonging to T.S. Ms. McMullen instructed Grievant and Ms. Spurlock to count the medications and destroy them. Both LPN's did as they were instructed. Grievant testified she believed what Ms. McMullen instructed her to do was inappropriate. She, along with four other nurses, submitted a written account of these events to the RN Board. G. Ex. 1. Grievant signed this complaint in good faith, believing she had a legitimate basis upon which to file a complaint against her supervisor.

Another complaint against Ms. McMullen involved the alteration by Pat Ramey of physician's order at the direction of Ms. McMullen, which has been more fully detailed above. As noted above, Grievant, along with the other nurses, took steps to report the conduct to the RN Board, and Kathy Spurlock reported Pat Ramey to the LPN Board. Again, Grievant testified she did so in good faith, believing that this type of conduct was properly brought to the attention of the RN Board.

Approximately four months after the initial complaint to the RN Board, Grievant was terminated from her employment. (See footnote 6) As noted above, she had no disciplinary action taken against her in the prior 12 months of employment. Pat Ramey testified that Ms. McMullen had threatened to retaliate against those nurses who had filed complaints against her. In a letter to Mr. Harper, Ms. Ramey expressed her fears regarding Ms. McMullen's threats, including suing those involved in the complaint against her, and replacing all of the LPN's with RN's. G. Ex. 5. At about the same time, Ms. Ramey attended a meeting with Mr. Hubbard, and reiterated her fear that Ms. McMullen was out to get their jobs. Ms. Ramey testified Ms. McMullen once told her she would like to “have a couple of jobs”, which Ms. Ramey interpreted to mean she would like to see a couple of people fired. LIV Trans., Vol. II, pp. 56.. Ms. Ramey eventually withdrew her name from the complaint against Ms. McMullen to the RN Board.

Kathy Hite, another LPN at the Veterans Home who signed the complaint to the RN Board against Ms. McMullen, did not withdraw her name. She testified she was threatened with discharge, suspension, and/or reprimand on January 13, 1998, for assisting Grievant and Ms. Spurlock in their grievances. (The level four hearing commenced on January 22, 1998). LIV Trans., Vol. II, p. 126. Ms. Hite testified she feels very threatened by Ms. McMullen. LIV Trans., Vol. II, p. 127.

Finally, Ms. McMullen herself testified she felt Grievant had created a hostile work environment

through her “threats” to file a grievance over the union pin. Clearly, Ms. McMullen has no understanding of the rights afforded state employees to file grievances against their employers.

Respondent recognized the potential for retaliation in this context. Nevertheless, it failed to investigate independently any of the charges made against Grievant by Ms. McMullen. Mr. Harper and Mr. Hubbard testified they relied upon Ms. McMullen's allegations and took the truth of the various charges against Grievant for granted. As the termination letter has been shown to be nothing more than trumped up charges, with the exception of a few minor incidents to which Grievant admits, I am left with no other recourse but to find that Ms. McMullen was motivated by a desire to retaliate against Grievant for her involvement in the charges against her to the RN Board. I am at a loss to understand what other reason there could be for such a gross misinterpretation of facts and events as is found in the dismissal letter.

Summary

Respondent proved three of the charges against Grievant: that she wore a union pin without authorization; that she made inappropriate jokes in the workplace about drugs and alcohol; and that she charted that she gave a resident two Percocet tablets in the morning, rather than charting she gave one in the morning, and the resident self-medicated with the other in the afternoon. In some cases where only a few of the charges have been proven, the Grievance Board has directed the employer to reevaluate the appropriate discipline to imposed. I decline to take this course in this case. It is clear that Ms. McMullen had decided to get rid of Grievant one way or the other, and it would serve no useful purpose to ask the agency to reevaluate whether Grievant should be dismissed for the proven charges. Further, the dismissal letter itself recites, “[w]hile no single example of inappropriate, counterproductive or unprofessional conduct would, by itself, warrant dismissal, the cumulative effect of your conduct and behavior is one of overall unsatisfactory and unacceptable performance.”

Discipline may be mitigated only if the penalty assessed is so clearly excessive or clearly disproportionate to the offense that it indicates an abuse of discretion. “Considerable deference is afforded the employer's assessment of the seriousness of theemployee's conduct and the prospects for rehabilitation.” Olah v. W. Va. Dept. of Health and Human Resources, Docket No. 96-HHR-055 (May 19, 1997). Factors to be considered in this analysis include the employee's past disciplinary

record, the clarity of notice to the employee of the rule violated, and whether the employee was warned about the conduct, and mitigating circumstances. Stewart v. W. Va. Alcohol Beverage Control Comm'n, Docket No. 91-ABCC-137 (Sept. 19, 1991). “[T]he work record of a long time civil service employee is a factor to be considered in determining whether discharge is an appropriate disciplinary measure in cases of misconduct.” Buskirk, supra.

The record does not reflect what Grievant's past performance was. The only evidence of Grievant's past performance is testimony from Ms. McMullen and Ms. Ramey that Grievant's performance began to decline in 1997. However, Grievant had not been disciplined for any reason in the 12 months preceding her termination.

I must conclude that wearing a union pin, and removing it upon being told to do so, and telling off-color jokes in the workplace, and again, refraining from doing so once being told about it, are not offenses warranting any discipline. Grievant's charting error is clearly something that needed to be corrected and perhaps she could have been disciplined for it at the time. However, no effort was made to counsel Grievant about this error when it happened. Further, while the dismissal letter alleges the resident involved received a medication error because of this mistake, the evidence has shown that he received exactly the dosage of medication he should have. Based upon the retaliation finding, no discipline should be upheld, unless Respondent demonstrates that such proven misconduct invariably results in a particular penalty. In these circumstances, Grievant was not shownto have committed any offense which would have resulted in a disciplinary action absent retaliatory motives.

The following findings of fact are made based upon the record developed at Level IV.

FINDINGS OF FACT

1. Grievant was employed by the VA as an LPN at the Veterans Home at Barboursville for approximately five years preceding her dismissal on November 12, 1997.

2. The Veterans Home is a residence care facility which houses approximately 68 disabled veterans, more than 90% of whom are emotionally disturbed or have a substance abuse problem. The Veterans Home provides no medical treatment, but the nurses maintain certain medical records, dispense prescribed medicine to some residents, take blood pressure readings, and give injections.

3. On July 9, 1997, Grievant left the nurses station in “C” Building to check on a fire alarm

panel trouble light in “B” Building. This did not violate any policy.

4. Grievant made inappropriate jokes in the workplace about drugs and alcohol.

5. Ms. Louise McMullen, Director of Nursing, spoke to Grievant about her inappropriate laughter in September 1997 and asked her if she need professional help.

6. Ms. McMullen did not hear anything further about Grievant laughing inappropriately following that discussion.

7. Grievant offered to write a letter to the LPN Board in support of co-worker Pat Ramey regarding an incident involving the alleged backdating of a physician's order at Ms. McMullen's request.

8. Ms. Ramey asked Grievant not to send the letter and she did not. 9. Grievant wore a union pin on her uniform on October 22 and October 23, 1997, without authorization.

10. Ms. McMullen asked Grievant to remove the pin on October 23, 1997, and provided her with a copy of the policy forbidding the wearing of any other pins or insignia on uniforms.

11. Grievant removed the pin when asked to do so by Ms. McMullen and did not wear it again.

12. Grievant did not want a letter of reprimand in her file over the pin incident and told Ms. McMullen she would file a grievance over that issue.

13. Grievant verbally told Ms. McMullen that resident M.H.'s medication had not arrived from the Veterans Hospital. Grievant followed up on the medication problem with telephone calls to the VA Hospital, as directed by Ms. McMullen, as well as charting her efforts in the 24-hour nurses report.

14. Ms. McMullen was aware that there was a problem with M.H.'s medication.

15. M.H. complained to the Veterans Home administrator and Director of Veterans Affairs about his medication, who, in turn, confronted Ms. McMullen.

16. Ms. McMullen asked Grievant to write an incident report regarding the medication problem, which she did. Ms. McMullen did not counsel or discipline Grievant at the time of this occurrence.

17. Grievant did not violate nursing protocol in the disposal of prescription medications on October 23, 1997.

18. Grievant improperly charted that she gave a resident two Percocet tablets in the morning, rather than one in the morning, and one self-medicated 6 hours later. Grievant did not commit a medication dosage error, but a transcription error with regard to this incident.

19. Grievant was one of five nurses who reported Ms. McMullen to the RN Board for various

complaints.

20. Ms. McMullen threatened to replace the LPNs with RNs following the complaint made against her.

21. Ms. McMullen threatened to sue everyone involved in making the complaint against her.

22. Ms. McMullen threatened to “have a couple of jobs.” Kathy Spurlock and Grievant were subsequently dismissed from their employment with the Veterans Home on the same day.

23. Grievant did not create a hostile work environment when she told Ms. McMullen she would file a grievance over the pin incident.

24. Ms. McMullen retaliated against Grievant for filing a complaint against her with the RN Board by trumping up the charges in Grievant's dismissal letter.

The following conclusions of law support the Decision reached.

CONCLUSIONS OF LAW

1. Pursuant to W. Va. Code § 29-6A-6, the burden of proof in disciplinary matters rests with the employer, and the employer must meet that burden by proving the charges against an employee by a preponderance of the evidence. Ramey v. W. Va. Dept. of Health, Docket No. H-88-005 (Dec. 6, 1988).

2. Respondent has proven that Grievant wore a union pin on her uniform without authorization on October 22 and 23, 1997. 3. Respondent has proven that Grievant told inappropriate jokes in the workplace about drugs and alcohol.

4. Respondent has proven that Grievant charged that she gave a resident two Percocet tablets at 7:20 a.m., instead of charting that she gave one tablet at 7:20 and the patient self-medicated with another tablet six hours later.

5.

Respondent failed to prove any of the other charges against Grievant.

6. Grievant proved that her dismissal was motivated by a desire for retaliation on the part of Ms. McMullen for her participation in filing a complaint against her to the Registered Professional Nursing Board, in violation of W. Va. Code §§ 6C-1-1, et seq.

Accordingly, this grievance is **GRANTED**. Respondent is **ORDERED** to reinstate Grievant to her

position as an LPN at the Veteran's Home, and to pay her all back pay and benefits to which she is entitled, as though she had not been dismissed, plus interest.

Any party or the West Virginia Division of Personnel may appeal this decision to the circuit court of the county in which the grievance occurred, and such appeal must be filed within thirty (30) days of receipt of this decision. W. Va. Code §29-6A-7. Neither the West Virginia Education and State Employees Grievance Board nor any of its Administrative Law Judges is a party to such appeal, and should not be so named. Any appealing party must advise this office of the intent to appeal and provide the civil action number so that the record can be prepared and transmitted to the appropriate court.

_____

MARY JO SWARTZ

Administrative Law Judge

Dated: April 7, 1998

Footnote: 1

The dismissal letter erroneously cites this provision as 12.1.5.1, which deals with impersonating another licensed practitioner, permitting another person to use his or her license for the purpose of nursing for compensation. Grievant was not charged with a 12.1.5.1 offense.

Footnote: 2

This dismissal letter erroneously cites this provision as 12.1.5.19, as Ms. McMullen was looking at an older version of the "Laws and Rules" when she assisted in drafting the dismissal letter.

Footnote: 3

The dismissal letter erroneously cites this provision as 12.1.5.22, as Ms. McMullen was looking at an older version of the "Laws and Rules" when she assisted in drafting the dismissal letter.

Footnote: 4

Ms. McMullen first testified she encountered Grievant "in Building B." LIV Trans., Vol. I, p. 31. Later she testified she saw Grievant coming from B Building. LIV Trans., Vol. 1, p. 170. Then she testified she was not coming from B Building. LIV, Trans., Vol 1, p. 178. Eventually, she settled on the testimony that she met Grievant on the landing between B and C Buildings.

Footnote: 5

The incident report form states it "is to be used for incident (Example: fire, incorrect administration of medicine, theft, abuse, violation of rules by residents or employees, etc.) Any accident or injury involving visitors, residents, vendors, volunteers, etc." The Veterans Home's Nursing Policy at Article V states that incident reports are to document "exceptional or noteworthy occurrance [sic] or events relating to the health, safety, welfare and or medical treatment of a resident, employees or visitor," and specifically, "any medication error of any kind."

Footnote: 6

Kathy Spurlock was also dismissed from her employment with the West Virginia Veterans Home on the same day as Grievant, and her dismissal is the subject of another grievance decision, Spurlock v. Division of Veterans Affairs, Docket No. 97-VA-504 (Feb. 27, 1998).