

STATE OF OHIO
STATE PERSONNEL BOARD OF REVIEW

Becky J. Chio,

Appellant,

v.

Case No. 10-REM-10-0273

Ottawa County Riverview Healthcare Campus,

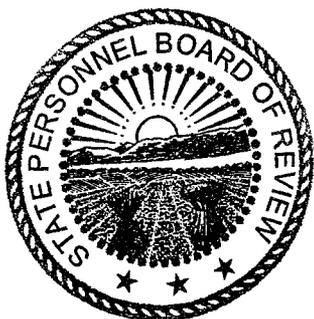
Appellee.

ORDER

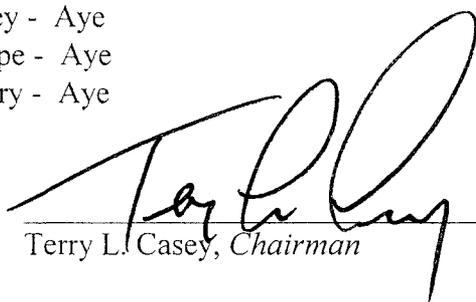
This matter came on for consideration on the Report and Recommendation of the Administrative Law Judge in the above-captioned appeal.

After a thorough examination of the record and a review of the Report and Recommendation of the Administrative Law Judge, along with any objections to that report which have been timely and properly filed, the Board hereby adopts the Recommendation of the Administrative Law Judge.

Wherefore, it is hereby **ORDERED** that Appellant's removal be **AFFIRMED**, pursuant to O.R.C. § 124.34.



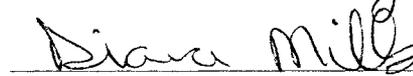
Casey - Aye
Lumpe - Aye
Tillery - Aye


Terry L. Casey, *Chairman*

CERTIFICATION

The State of Ohio, State Personnel Board of Review, ss:

I, the undersigned clerk of the State Personnel Board of Review, hereby certify that this document and any attachment thereto constitutes ~~the original~~ a true copy of the original order or resolution of the State Personnel Board of Review as entered upon the Board's Journal, a copy of which has been forwarded to the parties this date, August 22, 2011.


Diana Mills
Clerk

NOTE: Please see the reverse side of this Order **or** the attachment to this Order for information regarding your appeal rights.



**STATE OF OHIO
STATE PERSONNEL BOARD OF REVIEW**

Becky J. Chio,

Case No. 10-REM-10-0273

Appellant,

v.

July 6, 2011

Ottawa County, Riverview Healthcare
Campus,

Appellee

Jeannette E. Gunn
Administrative Law Judge

REPORT AND RECOMMENDATION

To the Honorable State Personnel Board of Review:

This cause came on due to Appellant's timely appeal of her September 24, 2010, removal from employment with Appellee. A record hearing was held in the instant matter on April 26, 2011. Appellant was present at record hearing and appeared *pro se*. Appellee was present at record hearing through its designee, Administrator Kendra German, and was represented by Lisa E. Pizza, attorney at law.

The R.C. 124.34 Order of Removal provided to Appellant listed as grounds for her removal:

On or about 08/07/10 you changed resident SL's dressing without being trained on the proper procedure to change this special dressing. A RN Supervisor was to be present during this dressing change to ensure it was done properly. Your improper dressing caused the wound to be further compromised.

On or about 8/9/10 while working St. 3 it was documented by PM RN Supv. that you finished your shift without properly following up on a resident's surgical wound, failing to chart about another resident's dressing change, failing to report a resident fall to his/her family member and missed multiple doctors' orders including a Coumadin medication change.

On or about 8/16/10 after your shift on St. 6, two (2) empty vials of Ativan were discovered in the top drawer of the med cart, not in the proper double locked narcotic box. These drugs were not part of the narcotic count done prior to you leaving at the end of your shift.

You have had prior discipline regarding poor judgment and failing to follow good nursing procedures.

STATEMENT OF THE CASE

Robin Pfeiffer testified that she has been employed by Appellee as its Human Resources Coordinator for approximately twelve years, and in that capacity serves as custodian of Appellee's personnel records. She confirmed that she participated in the investigation of the disciplinary charges which led to Appellant's removal from employment with Appellee.

Ms. Pfeiffer identified Appellee's Exhibit A as a copy of the R.C. 124.34 Order of Removal effective September 24, 2010, that was hand-delivered to Appellant. She confirmed that Appellant had notice of and participated in a pre-disciplinary hearing (Appellee's Exhibits B and C) held on August 30, 2010. The witness recalled that Ottawa County Human Resources Director Pam Courtney served as hearing office for the pre-disciplinary hearing and identified Appellee's Exhibit D as a copy of the hearing officer's report. Ms. Pfeiffer stated that she discussed Ms. Courtney's report and the information Appellant presented at the pre-disciplinary hearing with Administrator Kendra German prior to Ms. German's determination to remove Appellant from employment.

The witness identified Appellee's Exhibit E as a copy of Appellant's position description and noted that Appellant was responsible for providing patients with nursing care, administering medicine and maintaining records. Ms. Pfeiffer confirmed that Appellant had signed both her position description and Appellee's Exhibit F, stating that she understood her responsibilities. She observed that a copy of Appellee's policy manuals are kept at each nursing station and that Appellant had ready access to the manuals during her employment. The witness noted that Appellant also acknowledged in Appellee's Exhibit F that she was responsible for becoming familiar with all of the policies in the manual.

Ms. Pfeiffer testified that Appellant received regular job performance evaluations and observed that in her 2009 performance evaluation (Appellee's Exhibit G), Appellant's rater noted that Appellant needed to slow down and double check her actions, with the specific goal being to decrease errors. The witness confirmed that Appellant had received previous progressive discipline for medication errors and for failing to monitor and assess patients as ordered in patient records, ranging from a written warning in 2007 to a five day suspension in March 2010.

Kendra German testified she has been employed by Appellee as Administrator for approximately five and one-half years. She noted that she has overall responsibility for the operations of the facility. Ms. German indicated that when a nurse makes repeated errors, it places the residents and the facility at risk. The witness recalled that Appellant had been given several opportunities to improve her performance but did not demonstrate that her errors would be corrected in the future.

Charge #1: On or about 08/07/10, improperly changed a resident's dressing without being trained on the proper procedure and without an RN supervisor present.

Jean Marquette, who testified that she has been employed by Appellee as Director of Nursing since January 8, 2010, stated that Appellant's actions violated Appellee's wound care policy (Appellee's Exhibit J). She noted that the resident had a vacuum dressing, and that nurses who had not received in-service training in the appropriate procedures for this type of dressing had been specifically instructed to have a supervisor present when changing one. The witness stated that Appellant was working night shift when the in-service training was conducted and had not yet been trained in the procedure on August 7, 2010.

Ms. Marquette recalled that when the dressing was next changed, the shift nurse showed her that Appellant's improper application of the dressing had resulted in damage to the healthy skin surrounding the resident's wound. She testified that, in addition, not only did Appellant incorrectly note the time of the dressing change on the patient's progress notes (Appellee's Exhibit L), she also began changing the dressing before her supervisor was present (Appellee's Exhibit K).

Melanie Reinhart, confirmed that she was the day shift supervisor on August 7, 2010, and testified that she prepared a statement (Appellee's Exhibit K) as part of the investigation of the matter. She recalled that Appellant called to tell her that she

was ready to change the dressing, but that she was delayed in going to Appellant because she had to deal with an emergency within the facility. The witness indicated that when she finally arrived, Appellant was placing the last piece of plastic dressing on top of the wound vac; when the apparatus was plugged in, it functioned properly and did not show any leaks. Ms. Reinhart stated that she questioned Appellant about the manner in which she had applied the dressing and from Appellant's answers concluded that she had done it correctly.

Appellant testified that she was not aware that she was required to have special training to apply a wound vac dressing change or that she was not supposed to change the dressing without having a trained nurse present. She noted that she asked a State Tested Nursing Assistant (STNA) who had been present for other dressing changes of the same type to be present when she changed the dressing. Appellant recalled that she offered to take the dressing off the patient and reapply it once Ms. Reinhart was present, but stated that Ms. Reinhart said that the dressing looked okay.

Charge #2: On or about 8/9/10, (a) failed to properly follow up on a resident's surgical wound, (b) failed to chart a resident's dressing change, (c) failed to report a resident's fall to his/her family member, and (d) missed multiple doctors' orders, including a Coumadin medication change.

Ms. Marquette stated that Appellant was responsible for examining every patient on her station during her shift, and observed that Appellant's chart notes did not indicate that she examined the patient in Bed 311's surgical wound; shift notes from the following shift indicated that the wound site was significantly infected (Appellee's Exhibit P). Appellant recalled that she looked at the resident's surgical wound and palpated it, but did not conduct a thorough examination of the wound because he said it did not hurt and he was in a hurry to get to a therapy appointment. She noted that the resident had no complaints at the time she examined him and did not have an elevated temperature. Appellant conceded that she did not note her brief examination on the resident's progress notes.

Ms. Marquette recalled that the resident in Bed 309 fell during the shift prior to Appellant's, on the evening of August 8, 2010 (Appellee's Exhibits Q, R, S and T). She observed that Appellee's staff assessed the resident and completed the necessary reports regarding the incident, but that because the fall occurred after 11:00 p.m., they followed facility policies and did not contact the resident's family that evening. The witness explained that it was the responsibility of the nurse in the

oncoming day shift, in this case Appellant, to contact the family, notify them of the resident's fall, and record in the resident's records that family contact had been made. Ms. Marquette indicated that during the investigation of the incident, Appellant stated that she had mentioned to the resident's son, who was at the facility on August 9, that his mother "had a little slip" but did not chart their conversation. Appellant noted that she used the term "slip" in her conversation with the resident's son because those were the words used by the night nurse to describe the incident to her. Appellant recalled that the son was worried about his mother and concerned that his two children, who had accompanied him to the facility, were disturbing the residents. She agreed that she did not record her contact with the resident's son.

Ms. Marquette testified that nurses are responsible for noting physician orders given to them during their shift (Appellee's Exhibit U). She recalled that when Appellant ended her shift on August 9, 2010, she left a stack of faxes and paperwork that had not been completed. The witness noted that one of the faxes was a physician's order for Coumadin, which is an anti-coagulant. Ms. Marquette stated that Appellant's actions did not constitute good nursing practice, and she did not consider Appellant's explanation that she "just didn't get to it on her shift" to be reasonable.

Charge #3: On or about 8/16/10, failed to properly secure/discard two (2) empty vials of Ativan and failed to include them in the narcotic count done prior to the end of the shift.

Timberly Smith, who is employed by Appellee as a charge nurse, testified that she worked the shift immediately following Appellant's shift on August 16, 2010; she testified that when she opened the top drawer of the medication cart, she discovered two empty Ativan vials in the drawer. Ms. Marquette confirmed that the Narcotic Count Sheet for August 16, 2010 (Appellee's Exhibit BB), shows that Appellant signed out two vials of Lorazepam, which is the generic equivalent of Ativan.

Appellant confirmed that she signed out two vials of Ativan on August 16, 2010. She testified that she did not empty the vials (Appellee's Exhibit Z), and that she put the remaining medication in the top locked drawer of the medication cart. Ms. Marquette explained that Appellee's Controlled Substances policy (Appellee's Exhibit DD) requires controlled substances, such as Ativan, to be kept in a locked container at all times, except when accessed to obtain medications for residents.

She noted that the Ativan vials found in Appellant's medication cart should have been in a double-locked area if, as Appellant claimed, they were not empty. Appellant testified that the Ativan was double-locked, since the cart itself was locked, and the cart was in a locked room; Ms. Smith indicated, however, that the medication cart was in an unlocked room when she discovered the Ativan. Ms. Marquette testified that leaving the vials of Ativan in a locked drawer of an unattended medication cart would not be in compliance with Appellee's Storage of Medications policy (Appellee's Exhibit CC).

Ms. Smith testified and Appellant confirmed that nurses are supposed to "waste," or discard, unused medications prior to the end of their shift. Ms. Marquette noted that there must be two nurses present to discard "wasted" medications, and that the procedure must be documented on a count sheet (Appellee's Exhibit EE). She also noted that Appellee's policies (Appellee's Exhibit DD) also require nursing staff to count controlled drugs at the end of each shift and stated that the investigation of the matter indicated that the two vials of Ativan were not properly discarded at the end of Appellant's shift and were not included in the drug count at the end of Appellant's shift.

FINDINGS OF FACT

Based upon the testimony presented and evidence admitted at record hearing, I make the following findings of fact:

Appellant was removed from employment as a Licensed Practical Nurse (LPN) with Appellee, effective September 24, 2010. A copy of the R.C. 124.34 Order of Removal was hand-delivered to Appellant prior to the effective date of her removal. Appellant had notice of and an opportunity to participate in a pre-disciplinary hearing on August 30, 2010.

As an LPN, Appellant was responsible for providing residents with nursing care, administering medicine and maintaining records. Appellant had access to Appellee's policies and received regular job performance evaluations. Prior to her termination, Appellant had received progressive discipline for medication errors and for failing to monitor and assess patients as ordered in patient records, ranging from a written warning in 2007 to a five day suspension in March 2010.

On or about August 7, 2010, Appellant changed a resident's wound vac dressing without completing the in-service training to do so. Appellant's RN supervisor, Ms. Reinhart, was not present for the majority of the time the dressing was being applied. Although Ms. Reinhart indicated that the dressing appeared to have been properly applied, it was later determined that Appellant had improperly applied the dressing, which resulted in damage to the healthy skin surrounding the wound. Further, Appellant's notation of the time of the dressing change on the resident's progress notes was inaccurate.

On or about August 9, 2010, Appellant conducted a cursory examination of the patient in Bed 311's surgical wound, however, she failed to note her examination on the patient's chart notes. Similarly, she had a conversation with the son of the resident in Bed 309 that day, regarding that resident's fall on the previous evening, but failed to chart that she had made contact with the resident's family member. Finally, Appellant left paperwork, which contained a physician's medication order, uncompleted at the end of her shift.

On or about August 16, 2010, Appellant failed to properly secure, dispose of and/or account for two partially empty vials of Ativan, which is a narcotic medication and controlled substance. The vials were left unattended in a locked drawer of a medication cart that Appellant used on her shift, and were discovered by the nurse who worked the following shift. Appellee's policies require controlled substances to be secured in a double-locked area. Appellee's policies further require unused medications to be discarded prior to the end of a shift, and controlled substances must be counted by two nurses at the end of each shift.

CONCLUSIONS OF LAW

As in any disciplinary appeal before this Board, Appellee bears the burden of establishing by a preponderance of the evidence, certain facts. Appellee must prove that Appellant's due process rights were observed, that it substantially complied with the procedural requirements established by the Ohio Revised Code and Ohio Administrative Code in administering Appellant's discipline, and that Appellant committed one of the enumerated infractions listed in R.C. 124.34 and on the disciplinary order. The standard of proof required by this Board, a "preponderance of the evidence," means that Appellee must produce evidence which is of greater weight or more convincing than the evidence which is offered in

opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not.

With regard to the infractions alleged, Appellee must prove for each infraction that Appellee had an established standard of conduct, that the standard was communicated to the Appellant, that Appellant violated that standard of conduct, and that the discipline imposed upon Appellant was an appropriate response. In weighing the appropriateness of the discipline imposed upon Appellant, this Board will consider the seriousness of Appellant's infractions, Appellant's prior work record and/or disciplinary history, Appellant's employment tenure, and any evidence of mitigating circumstances or disparate treatment of similarly situated employees presented by the Appellant.

Due process requires that a classified civil servant who is about to be disciplined receive oral or written notice of the charges against him, an explanation of the employer's evidence, and an opportunity to be heard prior to the imposition of discipline, coupled with post-disciplinary administrative procedures as provided by R.C. 124.34. *Seltzer v. Cuyahoga County Dept. of Human Services* (1987), 38 Ohio App.3d 121. Information contained in the record indicates that Appellant was notified of and had the opportunity to participate in a pre-disciplinary hearing. Appellant had notice of the charges against her and an opportunity to respond to those charges. Accordingly, I find that Appellant's due process rights were observed. I further find that Appellee substantially complied with the procedural requirements established by the Ohio Revised Code and Ohio Administrative Code in removing Appellant from employment.

Testimony and evidence presented at record hearing established that Appellee had established standards of conduct for its employees. Appellee provided copies of applicable policies addressing Wound Care, Administering Medications, Documentation of Medication Administration, Storage of Medications, Controlled Substances, and Destroying and Discarding Medications. Appellee further established and Appellant did not dispute that Appellant had ready access to such policies during the time she was employed by Appellee. Accordingly, I find that Appellee had established standards of conduct that were communicated to Appellant.

This Board's scrutiny may, therefore, proceed to the merits of the charges made against Appellants. The first charge contained in the R.C. 124.34 Order of Removal was that Appellant improperly changed a dressing without completing

required training and without an RN supervisor present, on or about August 7, 2010. Appellant indicated that she did not know that she was required to have training on this specific type of dressing, and that she did not know that she had to have a trained nurse present when she changed the dressing. Appellant's own testimony somewhat contradicts this assertion, however, as she requested that her RN supervisor be present when the dressing was changed and, in her supervisor's absence, took care to have an STNA who had observed the application of similar dressings present. Accordingly, I find that Appellee has met its burden of proof to demonstrate that Appellant was aware of the training requirement for the application of wound vac dressings and of the requirement that an RN supervisor be present when an individual who had not received the training was applying the dressing, and that Appellant's conduct violated this requirement.

The second charge made against Appellant was that she failed to properly follow up on a resident's surgical wound, failed to chart a dressing change, failed to report a resident's fall to his/her family member and missed multiple doctor's orders, including a medication change. Testimony at record hearing established that while Appellant did conduct an examination of the patient in Bed 311's surgical wound, she failed to note her examination on the patient's chart notes. Testimony also established that although she had a conversation with the son of the resident in Bed 309, regarding the resident's fall on the previous evening, she failed to chart that she had made contact with the resident's family member. Finally, testimony indicated that on or about August 9, 2010, Appellant left paperwork, which contained a physician's medication order, uncompleted at the end of her shift. Although Appellee provided no policy specifically addressing the manner in which Appellant was required to maintain medical charts or her obligation to process doctor's orders on a timely basis, Appellant testified at hearing that she was aware of her responsibility to do so. Maintaining records reflecting residents' condition, medication and treatments, as well as maintaining an immediate complete and accurate update plan of care are both job duties clearly outlined in Appellant's job description (Appellee's Exhibit E), and I find that her conduct on or about August 9, 2010, violated the responsibilities associated with her employment as an LPN and communicated to her by Appellee.

The final charge made against Appellant was that she had failed to properly secure and/or discard two vials of Ativan and failed to include them in the narcotic count done prior to the end of her shift. Appellant did not dispute either that she failed to properly discard the two vials of Ativan that she left locked in the top drawer of the medication cart, or that they were not included in the end of shift count.

Appellant contended, however, that the vials were properly secured in a double-locked storage area, since they were in the top locked drawer of the cart and the cart was in a locked room. Ms. Smith testified that the cart was in an unlocked room when she discovered the vials, however, no testimony was elicited to establish how far into the next shift that discovery occurred, or how many other individuals had access to the room in which the cart was stored. Accordingly, I find the testimony to be insufficient to establish whether or not the Ativan vials were in a double-locked storage area; there is sufficient evidence, however, to support a conclusion that Appellant failed to properly discard the Ativan and failed to include it in the narcotic count.

R.C. 124.34(A) provides in pertinent part that:

The tenure of every officer or employee in the classified service of the state and the counties ... shall be during good behavior and efficient service. No officer or employee shall be reduced in pay or position, fined, suspended, or removed ... except as provided in section 124.32 of the Revised Code, and for incompetency, inefficiency, dishonesty, drunkenness, immoral conduct, insubordination, discourteous treatment of the public, neglect of duty, violation of any policy or work rule of the officer's or employee's appointing authority, violation of this chapter or the rules of the director of administrative services or the commission, any other failure of good behavior, any other acts of misfeasance, malfeasance, or nonfeasance in office, or conviction of a felony.

In the matter at hand, Appellee has successfully established that Appellant's conduct violated its policies and/or work rules. Appellant noted in mitigation that she had just returned to day shift in August 2010, after working night shift for approximately six months, and observed that she had difficulty acclimating to the shift change and the different duties required of day shift nurses. The record indicates that Appellant had a significant history of performance-related discipline over the approximately three-year period prior to her removal from employment. As Ms. German noted, when a nurse makes repeated errors, it places both the residents of the facility and the facility itself at risk. Accordingly, upon a review of all of the evidence contained in the record, I find that removal was an appropriate discipline in this instance.

Becky J. Chio
Case No. 10-REM-10-0273
Page 11

Therefore, I respectfully **RECOMMEND** that Appellant's removal be **AFFIRMED**.



Jeannette E. Gunn
Administrative Law Judge