ARBITRATION DECISION NO.:
267

UNION:
OCSEA, Local 11, AFSCME, AFL-CIO

EMPLOYER:
Department of Mental Retardation
and Developmental Disabilities,
Gallipolis Developmental Center

DATE OF ARBITRATION:
April 24, 1990

DATE OF DECISION:
June 11, 1990

GRIEVANT:
Belinda Burnett

OCB GRIEVANCE NO.:
24-07-(89-08-25)-0206-01-04

ARBITRATOR:
Hyman Cohen

FOR THE UNION:
Richard Sycks

FOR THE EMPLOYER:
Mike Friscardo

KEY WORDS:
Falsification
Suspension
Medication Error

ARTICLES:
Article 24 - Discipline
§24.01-Standard

FACTS:

The grievant is employed as a Licensed Practical Nurse (LPN) at the Gallipolis Developmental Center. The Center is a residential treatment center for approximately 300 developmentally disabled or mentally retarded people. Grievant failed to administer a medication to a patient. The patient became extremely hostile and had to be watched by another employee during grievant's shift. The policy for non administered medication is to record, initial and explain the incident. The grievant admitted that she did not administer the medication when confronted by another employee and a supervisor. Grievant, in a meeting with her supervisor, asked to amend the record of medication and treatment. She wrote that she had taken the same patient's pulse at a time when the grievant was not even in the area. When the supervisor warned her that

she could not have taken the patient's pulse at that time and that she should not falsify the record, the grievant crossed out the notation. The grievant was suspended for seven consecutive working days.

EMPLOYER'S POSITION:

The State believes that grievant intentionally tried to hide the fact she did not administer the medication. The failure to initially record plus the attempt to write in care that was not performed is suspicious. This can not be classified as a routine medication error, but a deliberate attempt to falsify medication records. Dishonesty and falsification of records are just cause for the grievant's seven day suspension.

UNION'S POSITION:

The Union argued that the grievant was planning on recording the fact that she had not given the medication to the patient, but the charts were not available to her. The grievant was also not aware that she was responsible for the patient. The Union also claims that grievant is subjected to disparate treatment. Medication errors "are routine" at the facility, but the grievant is the only employee to be disciplined for a medication error.

ARBITRATOR'S OPINION:

The arbitrator held that the State was correct in its belief; the grievant did try to hide the fact that she did not administer the patient's medication. The grievant offered no explanation of why she crossed out a patient treatment notation when her supervisor cautioned her against falsifying the medical records. The arbitrator believed the argument of the State that this was an attempt by the grievant to falsify medical records. The arbitrator also decided that the grievant had access to the medical charts if she had wanted to note the non administered medication.

AWARD:

The grievance is denied.

TEXT OF THE OPINION:

VOLUNTARY LABOR ARBITRATION

In the Matter of the Arbitration

-between-

STATE OF OHIO, OHIO DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES, GALLIPOLIS DEVELOPMENTAL CENTER,

-and-

OHIO CIVIL SERVICE EMPLOYEES ASSOCIATION, LOCAL 11, AFSCME, AFL-CIO

ARBITRATOR'S OPINION

Grievant:
BELINDA BURNETT

FOR THE STATE:

MIKE FRISCARDO
Staff Representative
Ohio Department of
Administrative Services
Office of Collective Bargaining
65 East State Street, 16th Fl.
Columbus, Ohio 43215

FOR THE UNION:
RICHARD SYCKS
Staff Representative
Ohio Civil Service Employees
Association, Local 11,
AFSCME AFL-CIO
8 Triangle Park
Cincinnati, Ohio 45246

DATE OF THE HEARING:
April 24, 1990

PLACE OF THE HEARING:
Ohio Department of
Administrative Services
Columbus, Ohio

ARBITRATOR:
HYMAN COHEN, Esq.
Impartial Arbitrator
Office and P. O. Address:
Post Office Box 22360
Beachwood, Ohio 44122
Telephone: 216-442-9295

*** * * * ***

The hearing was held on April 24, 1990 at the Ohio Department of Administrative Services, Office of Collective Bargaining, Ohio before HYMAN COHEN, Esq., the Impartial Arbitrator selected by the parties.

The hearing began at 9:45 a.m. and was concluded at 5:40 p.m.

*** * * * ***

On or about August 25, 1989 **BELINDA BURNETT** filed a grievance with the **OHIO DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES, GALLIPOLIS DEVELOPMENTAL CENTER**, Gallipolis, Ohio, the **"State"**, in which she protested a disciplinary suspension against her consisting of seven (7) consecutive working days beginning August 23, 1989. The grievance was advanced to the third step of the grievance procedure contained in the Agreement between the State and **OHIO CIVIL SERVICE EMPLOYEES ASSOCIATION, Local 11, AFSCME, AFL-CIO**, the **"Union"** where it was denied. As a result, the grievance was carried to arbitration.

FACTUAL DISCUSSION

The Grievant has been employed as a Licensed Practical Nurse [LPN] at the Gallipolis Developmental Center since August 8,1988. At the time of the events giving rise to the instant grievance, the Grievant

worked the second shift from 2:45 p.m. until 11:15 p.m. and was assigned to work on living areas 6047, 6048 and 6038.

The Gallipolis Developmental Center which is operated by the Ohio Department of Mental Retardation and Developmental Disabilities is a resident treatment center for three hundred (300) persons, most of whom are developmentally disabled or mentally retarded. At the Developmental Center direct care staff are assigned to eighteen (18) residential areas. Treatment and health care services are provided to the various persons who reside at the Center seven (7) days a week, twenty-four (24) hours a day. As direct care employees, LPNs are assigned on any given shift to a minimum of two (2) residential areas housing thirty-two (32) persons. The LPN is charged with the responsibility to provide the residents with prescribed medications and related health care treatments which are often directed toward the management of their behavior.

The events giving rise to the grievance occurred on June 21, 1989. Dorothy J. Plumley, a Therapeutic Program Worker was in Living Area 6038 with Michael H. a resident. Plumley's shift begins at 2:45 p.m. and ends at 11:15 p.m. When Plumley arrived at 6038 at the beginning of her shift, she indicated that Michael H was "hostile" but otherwise things were “pretty much normal”. Later into the shift Michael H. began to display aggressive behavior. Plumley was concerned enough about Michael H. that she decided to have him accompany her when she took her lunch break at 8:00 p.m. It was during her lunch break that she called Kimmie Lee, the Shift Supervisor, to advise her that she had been with Michael H. since the beginning of her shift and had not seen the LPN in 6038. She further indicated to Lee that the LPN was supposed to give Michael H. his 5:00 p.m. medication which he had not received. Plumley also asked Lee for the name of the LPN that was assigned to 6038. During the time that she was on Living Area 6038, Plumley was on a "one-to-one" coverage of Michael H.

Lee confirmed the telephone discussion with Plumley. When then proceeded to Living Area 6038 and did a "pill count" of "Xanox". According to her calculations her pill count added up to “1+” which means that there was “one (1) pill over the countable amount". After performing the pill count, Lee checked on Michael H. and found him "hyper" and aggressive.

When Plumley had called Lee and told her that she had not seen an LPN give Michael H. his 5:00 p.m. medication, Lee attempted to reach the Grievant who was assigned to Living Area 6038 but was unable to do so. While Plumley was in the break room with Michael H., she saw the Grievant who had just returned "from a walk". Plumley advised her that Lee had tried to get in touch with her. The Grievant telephoned Lee. The details of their telephone conversation are in dispute. However, it is undisputed that at some point in the telephone discussion, the Grievant told Lee that she had forgotten to give Michael H. his 5:00 p.m. medication.

Lee called Supervisor Jane Campbell, at her home and informed her of her telephone discussion with the Grievant. Campbell works the day shift which ended at 7:30 p.m. on June 21. Campbell returned to the Developmental Center and met Lee at approximately 9:30 p.m. Both Lee and Campbell did another pill count of Xanox and again the total was "1+". Campbell observed Michael H. and then reviewed the “Medex" which is a chart showing the nature of the medication given to a resident, the time it is given and by whom. If the medication is not given at a scheduled time, the initials of the nurse are circled and an explanation is “charted” or written on “Nursing Notes”. The Medex indicated that Michael H. had received both his 5:00 p.m. and 10:00 p.m. medications

During the evening of June 21 there were several discussions which the Grievant had with Lee and Campbell concerning her failure to give Michael H. his 5:00 p.m. medication. Moreover, the issue of whether the Grievant had the opportunity to gain access to the Medex in order to circle her initials with reference to the failure to give Michael H. his 5:00 p.m. medication, and to explain her failure to do so on Nursing Notes, are contested by the parties.

Campbell undertook an investigation of the events of June 21 after which the State imposed a disciplinary suspension of seven (7) days against the Grievant for “resident abuse /neglect and/or failure of good behavior (knowingly making false statements). Following the issuance of the disciplinary suspension, the instant grievance was filed.

DISCUSSION

The parties stipulated that the issue to be resolved by this arbitration is as follows: “Was the Grievant's seven (7) day suspension for just cause? If not, what shall the remedy be?" After carefully examining the evidence in the record, I have concluded that the State has proved by clear and convincing evidence that the Grievant's seven (7) days disciplinary suspension was for just cause.

TELEPHONE DISCUSSION BETWEEN LEE AND THE GRIEVANT

The State's case places great weight on Lee's account of her telephone discussion with the Grievant on June 21, 1989. The events which preceded the telephone call by the Grievant to Lee was Plumley's telephone inquiry to Lee as to who was the LPN assigned to 6038. Plumley who had been on "on a "one-to-one” coverage of Michael H. since 2:45 had been concerned with Michael H's. behavior. When she first arrived on 6038 she described Michael H. as "hostile" but further into the shift he became "worse". Plumley said that he had become "agitated, demanded attention, and talked about moving”; she went on to state that he began to display "aggressive behavior, stomping his feet and was very excited". When Michael H. "was getting uncontrollable”, she remembered that he did not receive his 5:00 P.M. medication. Thus, at approximately 8:00 p.m., while on her lunch break with Michael H., whom she did not want to leave because of his condition, Plumley called Lee to inquire about the identity of the LPN and told her about Michael H's. aggressive behavior.

When the Grievant came into the break room at approximately 8:25 to 8.30 p.m., Plumley told her that Lee had tried to get in touch with her. The Grievant telephoned Lee. Lee's account of the telephone discussion with the Grievant is as follows:

"I asked her if Michael H. got his 5:00 p.m. medication and she replied “yes". I asked her at what time and she said he got it late and I asked her again what time and she said approximately 7:30 p.m. and then I said I had been on the living area (6038) until 7:40 p.m. and at that time he did not have his medication. She kind of sighed and said she forgot it."

The Grievant's version of the telephone conversation with Lee is that “she wanted to know if I had given Michael H. his 5:00 p.m. medication". She said that she replied, "No, I did not know that he was on the [living] area until 8:30 p.m. when she saw him in the break room and she [Lee] said that I was in trouble”.

In my judgment Lee's account of the telephone discussion with the Grievant is trustworthy and credible. The details of her discussion with the Grievant and her persistence in questioning her on the time that she gave the medication to Michael H.; along with her recollection of the Grievant's "sigh” which indicated that she had been caught in a falsehood and was yielding to the truth, constitutes persuasive credible evidence.

I cannot conclude that Lee fabricated her version of telephone discussion with the Grievant. There is nothing in the evidentiary record to indicate that Lee possessed any personal bias of hostility towards the Grievant. Lee has nothing to gain by her testimony; but the Grievant had a great deal at stake. I believe that the Grievant told Lee that she gave medication to Michael H. at 7:30 p.m. However, the telephone discussion is only one (1) event in a sequence of events that occurred on June 21 which reinforce the State's case against the Grievant.

FACE TO FACE DISCUSSION BETWEEN LEE AND THE GRIEVANT

Following the telephone call from the Grievant, Lee said that she [the Grievant] came to the clinic and “was upset”. Lee said that she sat at her desk and "did not know what to say”. Lee testified that she told her that she “would probably be in trouble" and that she “would have to report it”. According to Lee, the Grievant asked “why would you have to call". Upon saying that she had already called her Supervisor [Campbell], and told her what happened, Lee said that the Grievant "was very upset" and left the clinic.

The Grievant said that after her telephone conversation with Lee she went to the clinic to ask her why she

was in so much trouble. According to the Grievant, Lee said that she called Campbell after which she asked if she [Lee] "had to do that" to which Lee replied, “yes". As I have already inferred Lee first told the Grievant that she would probably be in trouble during their telephone discussion, rather than during their face to face discussion as the Grievant had stated.

CAMPBELL'S TESTIMONY

I turn first to consider Campbell's testimony of a discussion with the Grievant in the break room. Campbell arrived on Living Area 6038 at approximately 9:25 p.m. and met Lee there at roughly 9:30 p.m. "Sometime after”, the Grievant entered the break room at the same time that Lee and Campbell were in the break room. By Campbell's account, the Grievant "said something to the effect that she was really in trouble”. Campbell testified that "she told her that she had a right to Union representation” but she [Campbell] had a right to ask her "How many Xanox” she gave to Michael H. According to Campbell, the Grievant said, "I did not give the 5:00 p.m. -- she said that she gave the 10:00 o'clock" -- and indicated "I gave only one (1) pill **. Meanwhile Lee was charting in her Nursing Notes on Michael H. and had come to the end of the sheet. The Grievant began writing her notes on a new Nursing Notes page by indicating that at "5:15" p.m. she took the pulse of Michael H. When she noticed what the Grievant had written, Campbell testified that she told her “you were not in the living area at 5:15 and thus any notation at 5:15 is false documentation". Campbell went on to state to the Grievant that when Lee finished writing her Nursing Notes, she [the Grievant] "may chart the actual time she was there [on the living area] and any truthful information that she wanted to".

Campbell said that she asked the Grievant for her statement of her account of what happened. She indicated that she then instructed Lee to copy the Medex inasmuch as “all the medications were documented as given" and to copy the Nursing Notes.

Campbell returned to her office. A short time thereafter, the Grievant entered her office. Campbell described her as "tearful, crying and begging [her] not to tell Dr. Kemp our Medical Director -- she said can’t we just forget this and my reply was to the effect, do not ask me not to do my job because you choose not to do so**.”

The Grievant's testimony on the events covered by Campbell's testimony is that she went to the break room at about 10:25 p.m. and told Campbell that she needed to chart notes on Michael H. She also wanted the Medex so she could circle her initials which would indicate that she did not give medication to Michael H. According to the Grievant, Campbell gave her a blank sheet on which to write Nursing Notes. When she “started writing”, the Grievant said that Campbell told her that if she falsifies the document, she would be in trouble. According to the Grievant, Campbell took the Nursing Notes sheet, and told her that Lee needed it to complete her documentation.

In evaluating the testimony of Campbell and the Grievant on their conversations, during June 21, 1989, it is of great weight that when the Grievant began charting notes on Michael H. she wrote that she had taken his pulse at "5:15". The Grievant had already admitted to Lee that she had forgotten to administer Michael H's. medication at 5:00 p.m. Indeed, the Grievant said that in her telephone discussion with Lee, she told her that she did not know that Michael H. was on 6038 until 6:30 p.m. when she first saw him in the break room with Plumley. In light of these considerations it is astonishing that in charting her notes on Michael H., she began by writing that she took his pulse at "5:15" p.m. There is a line drawn across "5:15", along with the word "error" and the initials of the Grievant.

It must be underscored that the Grievant did not explain the reason for writing that she took Michael H's. pulse at “5:15” p.m. In the absence of any explanation by the Grievant, it is reasonable to believe that had Campbell not informed her of the trouble that she would face if she falsified documentation, the Grievant would have falsified the time on the Nursing Notes when she took Michael H's. pulse.

Furthermore, the Grievant did not dispute the remainder of Campbell's testimony, including her account of what took place in her office. Indeed, she did not provide any testimony on the discussion in Campbell's office. Accordingly, I have concluded that the Grievant pleaded with her not to disclose to the Medical Director what had happened that evening.

MEDEX

Before considering the Medex, it would be useful to discuss the medication that the Grievant was required to have administered to Michael H. on June 21. Campbell characterized Michael H. as a resident who was aggressive and at times he displayed "destructive behavior". The "goal" of the facility was to have Michael H. in the "least restrictive environment possible" and that it was to be "controllable". The medication that the Grievant was to have administered at 5:00 p.m. was Xanox which Campbell described as a "psychotropic" medication. Elaborating, Campbell said that Xanox was an anti-anxiety or anti-depressant medication, which is administered to residents with mental health problems.

As I have already indicated, the Medex is a chart that is maintained by the nurses on the medication given to residents and the time that they are administered. Evidence at the hearing established that when the Medex is not initialed by the nurse on the living area for a particular medication for a patient, it means that the medication has not been given. When the Medex is initialed, it means that the medication has been poured and administered as scheduled. When the initials of the person pouring the medication is circled on the Medex, it means that the medication was not administered as prescribed and an explanation is placed in the Nursing Notes.

After her telephone discussion with Lee, the Grievant said that she took Michael H's. pulse rate. She then went to the medicine room and set up the medications. By this time, the Grievant said, it was close to 9:00 p.m., and she gave Michael H. his medication at approximately 9:00 p.m. It is undisputed that medication can be administered within an hour before or after the scheduled time required. Thus, since Michael H. was scheduled to receive Xanox at 10:00 p.m., the Grievant is permitted to administer his medication any time between 9:00 p.m. and 11:00 p.m.

It is undisputed that the Medex for the Grievant's medication of Xanox was initialed by the Grievant for 5:00 p.m. and 10:00 p.m. After administering the medication to Michael H. at approximately 9:00 p.m., and after her face to face discussion with Lee, the Grievant said that she went to the medicine room to circle her initials and to "finish charting" the Nursing Notes. As I previously indicated the circling of her initials on the Medex for Michael H's. 5:00 p.m. medication means that the medication was not administered. The failure to do so is explained in the Nursing Notes. In any event, the Grievant said that the Medex, and the Nursing Notes were "gone" from the medicine room. She proceeded to the break room where she saw "C. Pack" a Therapeutic Program Worker and Campbell. According to the Grievant, Campbell had the "Medex and the chart". The Grievant said that she was "denied the Medex and the chart". The Grievant said that she went to 6038 and told Lee that she needed the chart and the Medex. According to the Grievant, Lee told her that Campbell did not want to see her or talk to her that evening. After passing medication to her clients who returned from the workshop, and after she "did treatments", the Grievant said that she went back to the breakroom at approximately 10:25 p.m. She asked Campbell for the Medex and the chart so that she could circle her initials which would indicate that she did not give her medication to the Grievant and explain her failure to do so on the Nursing Notes. As I have previously indicated, Campbell gave her a blank nursing note on which the Grievant proceeded to write that at "5:15 p.m." she took Michael H's. pulse". When Campbell saw that the Grievant wrote "5:15" p.m. she warned her that if she falsified the document she would be in trouble. As I have already indicated, the Grievant then stated that Campbell took the Nursing Notes sheet and said that Lee needed it to complete her documentation. According to the Grievant, she told Campbell that she would return later "to do the documenting".

After getting medication for a patient at approximately 10:30 p.m. the Grievant testified that she called Anna M. Hamilton, President and Steward of the Union, at home. She told her "what was going on". According to the Grievant, Hamilton told her to get the chart and medication in order to complete the documentation. The Grievant then went to 6038 and the Medex and Nursing Notes "were gone". After calling Hamilton again, Hamilton told her to "try again" to complete the documentation. The Grievant said that she then went to the clinic to request the Medex and Nursing Notes from Lee but Naomi Durst, the night shift RN told her that both Lee and Campbell had left for the night. The Grievant said that she clocked out at 11:15 p.m. without getting a chance "to document".

Based upon the Grievant's testimony, the Union argues that she had an intention to circle her initials on the Medex and to make the appropriate entries on the Nursing Notes but management withheld both the charts and the Medex from her. However, the Grievant's testimony is unconvincing. I cannot conclude that for the withholding of the Medex and Nursing Notes by management, she would have circled her initials on the Medex. It cannot be overlooked that when the Grievant began writing on the Nursing Notes she wrote that she took Michael H's. pulse at "5:15" p.m. which is patently false. She never explained her reason for writing "5:15" and as a result the reasonable inference to be drawn is that she intended to falsify the Nursing Notes as to when she took Michael H's. pulse. Thus, although the Grievant intended to falsify the Nursing Notes concerning the time that she took Michael H's. pulse, the Union claims that she nevertheless intended to circle her initials on the Medex for the 5:00 p.m. medication, were it not for management's refusal to permit her to have access to the Medex and the Nursing Notes. The evidentiary record does not support this position.

I turn to consider the State's evidence on this aspect of the dispute between the parties. Lee said that she did not withhold the charts from the Grievant on June 21. She said that the charts were removed from the ward area at approximately 10:15 p.m.
Furthermore, Lee indicated that the Grievant did not contact her for the charts on June 21. Campbell said that the Grievant asked for the Medex and the chart while Lee was charting. Campbell said that the only time that she did not permit the Grievant to chart was while Lee was charting.

On the basis of the evidentiary record, I have concluded that the Grievant had an opportunity to circle her initials on the Medex after approximately 8:30 p.m. and before Lee began documenting the Nursing Notes. Moreover, had she waited for Lee to complete her charting, the inference to be drawn is that she would have been able to chart. It should be underscored that when the Grievant began to chart, she wrote that she took Michael H's. pulse at “5:15” p.m. which is false. In addition, there is no evidence that in any of her discussions with Lee and Campbell up to approximately 10:30 p.m. the Grievant intended to circle her initials. Indeed, in light of the Grievant's telephone discussion with Lee in which she belatedly admitted that she forgot to administer medication to Michael H. at 5:00 p.m. and her pleading to Campbell not to disclose to the Medical Director her failure to give medication to Michael H., leads me to infer that she did not intend to circle her initials. By doing so, the Grievant would have to explain her failure to give medication to Michael H. The evidence indicates that since she acknowledged that she was in trouble for forgetting to administer medication at 5:00 p.m. to Michael H., I cannot infer that she would have documented such an admission in the Nursing Notes during the evening of June 21.

FAILURE TO DISCOVER THE PRESENCE OF MICHAEL H ON LIVING AREA 6038

The Grievant said that she went to Vicki Kern, the Day Shift Supervisor, LPN at the start of the shift on June 21, and received the keys to the assigned areas. She went on to testify that Kern told her of problems in the area but she failed to mention to her [the Grievant] that Michael H. was on the area at the time. The residents attend a workshop, and the Grievant said that they leave around 2:00 p.m. and return at 9:30 p.m. It should be noted that residents are “held back" from the workshop due to behavior problems or illness. From May 19 through at least June 21, 1989, Michael H. had been held back from programming because of an incident in which he "tried to wreck a bus while fighting with another resident". As Campbell explained, "for his own safety as well as the safety of the other clients he did not go to workshop" on June 21. Thus, it was not until 8:30 p.m. when the Grievant said that she saw Michael H. with Plumley in the break room that she realized that Michael H. did not go with the other residents to the workshop.

The Grievant acknowledged that she did not ask Kern what residents, if any, did not attend the workshop on June 21. The Grievant had also admitted that she had been on living area 6038 on three (3) separate occasions before June 21. Thus, she was not unfamiliar with Michael H. or the other residents on the area. In any event, in light of the evidentiary record, I have concluded that the Grievant was aware that Michael H. was on living area 6038. She impliedly admitted as much in her telephone discussion with Lee when she eventually stated to her that she had forgotten to give Michael H. his 5:00 p.m. medication. Moreover, I find

it highly unusual that the Grievant never bothered to check on living area 6038 at any time between 2:45 p.m. and approximately 8:30 p.m.

DISPARATE TREATMENT

The Union claims that the State treated the Grievant in a disparate manner by imposing a six (6) day disciplinary suspension against her for the events of June 21. The Union, in effect, contends that the Grievant was the only nurse ever disciplined for committing a "medication error".

It is undisputed that medication errors "are routine" at the facility. Campbell acknowledged that such errors “are not part of the disciplinary grid”. Mona Vallance, an RN indicated that there are “around ten (10) medication errors every month by either an LPN or RN. Among the "medication errors" Vallance stated are "wrong medications, pharmaceutical mistakes”, and "wrong labels"; Vallance said that occasionally the medication for a resident is changed but the nurse nevertheless administers the initial medication that is prescribed.

The evidentiary record warrants the conclusion that the Grievant did not commit merely a “medication error". The Grievant at first falsely represented to Lee that she administered Michael H's. 5:00 p.m. medication. After being told by Lee that, in effect, she could not have given the medication to him, even at 7:40 p.m., did the Grievant admit that she had forgotten to give Michael H. his 5:00 p.m. medication. Furthermore, the Grievant falsely represented in writing on the Nursing Notes that she took Michael H's. pulse at "5:15” p.m. It was only after Campbell told her that she would be in trouble for providing false documentation that the Grievant drew a line through 5:15 and indicated that it was an error. Finally, the Grievant failed to circle her initials on the Medex although she had the time and opportunity to do so. Thus, I have inferred that she intended to convey that she gave the medication to Michael H. but in fact, she had not done so. Accordingly, the Grievant's conduct does not merely constitute a "medical error” as described by Vallance, but a serious violation of the Grievant's duties.

There is another segment of the Union’s claim of disparate treatment which must be considered. The episode in question took place on June 11, 1989 and involved LPN Susan Moore and Michael H. On that day Michael H. was extremely aggressive and there was permission given by the doctor to place restraints on Michael H. Vallance informed Moore that at 5:00 p.m. she was to give Michael H. his pill and she was to write an order for restraints. Vallance said that Moore did not give Michael H. his pill;- nor did she write the order for restraints. Vallance remained in the living area until 6:55 p.m. and did not see Moore. As a result Vallance "added the order for restraints and for an IM" (Intra-Muscular) injection. Vallance called Campbell at her home and informed her of the events that involved Michael H. and that Moore did not give him his 5:00 p.m. medication and did not write the order for restraint.

Moore's version of the episode was that she went to the living area to give Michael H. his medication but he was "blowing” -- "the staff was holding him down and Dolores Williams, the RCS who is in charge of the living area, told her not to give him any medication because he would choke on it. As a result, Moore went back to the medicine room with the pill. Moore reported these events to Vallance and was told that she [Vallance] would have to call the doctor and get an order for restraints and an IM injection. According to Moore, Vallance told her that she would get back to her. Moore had three (3) areas to cover and acknowledged that she was not fast inasmuch as she was a "new" employee. Moore asked the staff and the "RCS” whether she was "still needed" because she wanted to cover her other areas. When they told her that they had “everything under control", she went to another living area. When Moore returned to the living area 6038, she was informed that everything was under control and that the pill had been given to Michael H. Moore denied that Vallance told her to write an order for restraints and the IM.

Vallance prepared a report on the episode, and indicated that Moore had not given Michael H. his 5:00 p.m. medication; nor did she order in writing, the restraints for Michael H. Vallance further indicated in her report that Moore did not come to the area until approximately 7:00 p.m.

Upon receiving Vallance's report, Campbell investigated the episode by talking to both Vallance, Moore and Williams. Campbell confirmed Moore's testimony that she was told not to give Michael H. his pill at 5:00 p.m. Campbell said that during the time period referred to by Vallance, Moore had to administer "eight (8)

enemas" and was busy in the "tub room". Campbell also said that Moore told her that Vallance refused to talk to her when she called.

The evidence on the June 11 episode leads me to conclude that it is entirely dissimilar from the events of June 21, involving the Grievant. Moore was told by the staff not to administer the 5:00 p.m. medication to Michael H. because in light of his behavior at the time he would choke if the pill were administered. Furthermore, she was taking care of other patients during the relevant period of time on June 11. Campbell also conducted an investigation and exonerated Moore of any wrongdoing.

By contrast, the Grievant initially misrepresented that she gave the medication to Michael H. and then retracted her statement when Lee caught her misrepresenting the truth. The Grievant continued to misrepresent the truth by writing in the Nursing Notes that she took Michael H's. pulse at "5:15" p.m. She drew a line through 5:15 when Campbell informed her that falsifying documentation would get her into trouble. Furthermore, the Grievant's initials on the Medex for the 5:00 p.m. medication indicated an intention by her to convey that she gave such medication to Michael H., but in fact she had not done so. The differences between the June 11 and June 21 episodes are dramatically different. I have therefore concluded that the Union failed to prove that the State treated the Grievant in a disparate manner by imposing disciplinary suspension of seven (7) days against her.

CHANGING OF POLICY

Joanne Deel, an LPN at the Gallipolis Developmental Center said that since June 11, 1989 LPNs are required to write their assigned areas on a calendar so that the staff will know the identity of the LPNs who are assigned to specific Living Areas and where they are located during the shift.

Despite this change of policy by the State, it is of no assistance to the Union's case. The Grievant's actions in part may very well have lead to the change in policy. However, the Grievant's misrepresentation of facts by conveying that medication has been given when in fact it had not been is an extremely serious offense.

The State's failure to have in place a policy requiring LPNs to indicate where they are located during the shift, which it promulgated after June 21, did not contribute to or cause the Grievant's conduct. Accordingly, the State's change of policy which enables staff to know of the whereabouts of LPNs during the shift and the LPNs assigned to specific Living Areas are of no weight.

PENALTY

The events of June 21, 1989 took place approximately one (1) year after the Grievant was first employed at the facility. Less than three (3) weeks before June 21, the Grievant received a written reprimand because she neglected to perform a dressing change on a resident who was discharged from the hospital.

Based upon the evidentiary record, I have concluded that on June 21, 1989 the Grievant committed a “major offense”. In the Gallipolis Developmental Center Administrative Policy #2-76, a “major offense" is defined in relevant part as "an incident where disciplinary action need not follow the progressive corrective action sequence". At page 2. The Grievant's misstatements of fact concerning her failure to give Michael H. his 5:00 p.m. medication is a serious abuse of trust, given the nature of the care provided to the residents and illness of the patients. I find that the penalty imposed by the State does not violate Article 24, Section 24.02 of the Agreement which in relevant part provides: "Disciplinary action shall be commensurate with the offense". Based upon the evidentiary record, the State has proved by clear and convincing evidence that the Grievant's disciplinary suspension of seven (7) working days is for just cause. Moreover, it is commensurate with the serious offenses she committed on June 21, namely "resident abuse/neglect and/or failure of good behavior [knowingly making false statements].

AWARD

In light of the aforementioned considerations, the grievance is denied.

Dated: June 11, 1990

Cuyahoga County
Cleveland, Ohio

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