STATE PERSONNEL BOARD, STATE OF COLORADO
Case No. **2009B016(C)**

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

JUDY WILDAY-O'NEILL,

Complainant,

vs.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

Administrative Law Judge ("ALJ") Mary S. McClatchey held the hearing in this matter on February 10, 11, 12, and 26, 2009 at the State Personnel Board, 633 - 17th Street, Courtroom 6, Denver, Colorado. The record was closed by the ALJ at the conclusion of the hearing. Complainant appeared and represented herself. Her advisory witness was Terry O'Neill. Assistant Attorney General Michael Scott represented Respondent, Department of Human Services, State Veterans Home – Fitzsimons ("Fitzsimons"). Respondent's advisory witness was Brad Honl, Administrator of Fitzsimons, the appointing authority.

MATTER APPEALED

Complainant, Judy Wilday-O'Neill ("Complainant") appeals her April 29, 2008 letter of sanction and her disciplinary termination of employment as a Registered Nurse by Respondent, asserting these actions were in violation of the State Employee Protection (Whistleblower) Act. Complainant seeks reinstatement and back pay.

For the reasons set forth below, Respondent's action is **affirmed.**

ISSUES

1. Whether Complainant committed the acts for which she was disciplined;

2. Whether Respondent's action was arbitrary, capricious or contrary to rule or law;

3. Whether the discipline imposed was within the reasonable range of alternatives available to the appointing authority.

FINDINGS OF FACT

General Background

1. Complainant was employed as a Registered Nurse at Fitzsimons in the sub-acute unit from November 2006 until her termination in July 2008. Patients on the sub-acute unit are one step down the intensive care unit. They require close monitoring and a high level of care.

2. Fitzsimons is a nursing home with a patient population of predominantly male World War II veterans in their 80's.

3. Complainant received a Level 2, Consistently Meets Expectations, annual performance evaluation on April 21, 2008.

HIPAA

4. The Health Insurance Portability and Accountability Act (HIPAA) establishes regulations for the use and disclosure of Protected Health Information (PHI). PHI is any information held by a covered entity which concerns health status, provision of health care, or payment for health care that can be linked to an individual. Respondent is a covered entity under HIPAA.

5. Under HIPAA's "minimum necessary principal," only those medical staff that are directly responsible for treating a given patient may have access to that patient's PHI. Medical staff not treating a patient have no necessity of accessing such information and are therefore prohibited from doing so.

6. HIPAA requires a covered entity to investigate all alleged violations of the law and to impose corrective action when a violation occurs. The law mandates that a range of sanctions be imposed on any individual who violates the law. For first offenders who make an honest mistake or inadvertent disclosure of PHI, the law mandates that the individual be verbally coached and trained on the HIPAA law.

7. In those cases where a HIPAA violation has occurred, but no source of the violation can be identified, HIPAA requires that the Compliance Officer train every single staff member in the institution.

8. All Fitzsimons nursing personnel are required to sign a HIPAA Security Awareness and Training Confidentiality Statement, acknowledging their understanding of the following: "I will maintain in strictest confidence the Protected Health Information to which I have access. I will not share any confidential information with others who are not authorized, including other staff members, friends or family. I will use my access to Protected Health Information for the sole purpose of conducting legitimate business of the CDHS." Complainant signed this Statement on November 28, 2006.

HIPAA Awareness Training

9. HIPAA requires each state to have a HIPAA Privacy and Security Officer, whose responsibility it is to monitor and enforce compliance with the privacy component of the law. Kathryn Foo is the HIPAA Privacy and Security Officer for DHS.

10. Ms. Foo reports to the federal government and not to any individual at DHS. Her role is to advocate for patient privacy rights at all covered entities in the State of Colorado.

11. On August 13, 2007, Ms. Foo presented a training to the Fitzsimons staff on HIPAA compliance. She handed out a test to all present, including Complainant. Question #5 on the test consisted of the following: "You should apply the minimum necessary principal to which of the following? a. Service/Healthcare providers, b. Co-workers, c. Family members, or d. All of these answers are correct.

12. The correct answer to Question #5 was D. Complainant answered Question #5 correctly.

February 2008 Corrective Action and Education Plan

13. On February 12, 2008, Complainant received a Corrective Action letter for failing to provide appropriate patient care to a resident, E.H. According to the letter, on January 5, 2008, Complainant was the nurse in charge of E.H, who was doing poorly all day. Complainant did not document any assessment of his change of condition in his medical record. Late in Complainant's shift, the doctor wrote a "stat" order for E.H. A "stat" order is one that must be immediately executed by nursing staff. Complainant was aware of the stat order and E.U.'s poor condition, but did not implement the stat order prior to completing her shift. Instead, she informed the on-coming nurse that there were orders to implement.

14. The Corrective Action stated, "This is poor nursing judgment which led to a delay in resident care, this is a very sick resident and his needs should have been your main focus and you should have been aware of the need to check with the doctor an (sic) see if she had anything for you take care of immediately. This type of nursing care is unprofessional and will not be allowed to continue."

15. The Corrective Action was signed by Fitzsimons Administrator Brad Honl and Frances Holiday, Director of Nursing at that time.

16. The Corrective Action placed Complainant on an education plan, requiring her to attend training modules in patient assessment, nursing negligence and

documentation, by March 1, 2008. In addition, Complainant's nursing practice was to be monitored and assessed by the Unit Manager for the next 60 days. The Corrective Action noted that Complainant's failure to improve her assessment skills or to complete the education plan could result in further corrective and/or disciplinary action.

17. Complainant grieved and appealed the Corrective Action to the Colorado State Personnel Board. The appeal was dismissed.

18. Complainant was placed on an Education Plan in February 2008, under which she was required to take on-line courses in Long Term Care – Resident Assessment: Physical, Cognitive and Sensory Functioning, Legal Aspects of Nursing – Nursing Negligence: Protect Yourself, Protect Your Patients; and Nursing Communication – Communications: The Process. In addition, for a period of two weeks she was shadowed by another RN, and her Unit Manager signed off on all assessments. At the end of thirty days, her nursing practice would be evaluated for areas in need of improvement.

March Contacts with HR Director

19. In mid-March 2008, Complainant called the Human Resources Director for DHS, Brad Mallon. She informed him of several issues she was concerned about at Fitzsimons: infection control; staffing; medication errors; a nurse sleeping on duty during the night shift; nursing staff failing to implement doctors' orders at beginning of shift; language barriers between staff; and unprofessional behavior by staff in front of patients.

20. At the meeting, Mallon suggested to Complainant that she schedule a meeting with Brad Honl, Nursing Home Administrator for Fitzsimons. Mallon called Honl to inform him of the conversation and to encourage him to meet with Complainant regarding her concerns. Complainant did contact Honl and he invited her to meet with him in order to discuss the issues of concern to her.

21. On March 29, 2008, Complainant's husband, Terry O'Neill, sent an email to Mallon regarding "Thefts." The email stated that Complainant had come home "very disturbed and depressed" and had informed him that a staff member had reported to her there had been "substantial thefts of food stocks by kitchen employees." O'Neill stated that Complainant had reported it to a supervisor, who didn't want to do anything about the issue because "superiors know about the thefts." O'Neill said that Complainant had no personal knowledge regarding the thefts.

22. O'Neill continued, "Judy feels that she has been placed in a very stressful and difficult situation, wishing only that things would get back to where she can focus on her job. Judy is overwhelmed and not doing well and is dealing with much depression and stress. It would be good if she could get some help in dealing better with all she has experienced. Sorry to lay this on you, but I really didn't know what else to do."

23. On March 31, 2008, Mr. O'Neill emailed Mallon again, regarding, "Problems."

He stated, "Judy came home tonight and shared some things with me that are truly astounding. We finally have an understanding of why the things that have been done to her have happened. As she has told you, she has been previously unable to understand why she has been retaliated against so strongly for simply bringing some concerns about patient care and nursing practice problems to the attention of superiors." He stated that Complainant had been "made aware that there is some criminal activity that has been occurring for some time," and that employees believe superiors know about it. Complainant had informed the Director of Nursing. He indicated that as a veterans advocate he was concerned for Fitzsimons and its residents. "Take my advice and act decisively before this all goes to hell and no one can contain the damage."

March 25, 2008 Meeting with Honl

24. Honl scheduled the meeting with Complainant for March 25, 2008 and requested that Madline SaBell, Employee Relations Officer, be present to take notes.

25. Complainant brought a list of concerns to the meeting entitled "More Complete List of Concerns To Be Discussed at March 25 Meeting." She gave the list to Honl and discussed each item individually at the meeting.

26. At the meeting, Honl informed Complainant that he was previously aware of several of the areas of concern she discussed. He listened to her concerns, informed her of the actions he had previously taken, and committed to follow up on matters which had not been addressed, where appropriate. The issues were as follows:

A. Infection Control Issues. Complainant was concerned about insufficient room sanitizing which contributed to the spread of C-Diff, which is a bacterial infection that spreads easily in nursing homes and is difficult to contain.

B. CNA (Certified Nurse Aide) staffing issues. Complainant indicated that the short-staffing of CNA's was resulting in utilization of RN's and LPN's for duties normally completed by the nurse aides and a higher incidence of patient falls, especially in times of high patient census.

C. RN's were unable to take breaks or lunch due to workload demands and were not being paid for the additional time at work.

D. Medication problems. A topical medication had been left near a patient and was fed by mouth by a family member to the patient in error, revealing a need to address medication errors and oversights.

E. Nursing staff were sleeping on duty during the night shift and not completing their work. Chart checks; treatments; care plans; and consults were not being performed by night nurse staff, increasing the workload for day shift nursing staff. Night shift staff were refusing to perform patient baths and failing to refill

the portable oxygen tanks.

F. Relief shift staff were not implementing new orders implemented by doctors, even when advised that the doctor had written new orders. Staff were misrepresenting who was responsible.

G. Communication issues existed between staff who speak English and those for whom English was a second language. This language barrier could lead to erroneous sharing of critical patient information.

H. Dietary staff and nurse aides were engaging in unprofessional conflicts in front of residents; nurses did the same.

I. A hostile work environment existed at Fitzsimons, consisting of "discriminatory actions and threats, unsupportive supervision, low employee morale, extremely disrespectful treatment of staff by a superior, and shift versus shift."

J. Dietary staff refuse to go to the kitchen for residents to obtain requested food items.

K. No gowns are available for ill patients.

L. There are problems with getting needed supplies.

27. On April 1, 2008, Honl sent Complainant a memorandum responding to each of the issues raised at the March 25 meeting. His response contained the following:

A. Infection Control. Honl noted that on March 13, 2008, he had directed the Infection Control Officer at Fitzsimons, Amanda Thornton, to address the issue of C-Diff in the facility, Thornton had completed the plan (which was attached), and he had included the Housekeeping Director in addressing sanitation efforts.

B. Staffing. Honl noted that Complainant had said at the meeting that there was not presently a shortage of CNA staff. He indicated that Heritage Left unit did have one R.N. vacancy. Honl stated that while he would like to increase the number of nurse aides, staffing ratios were within acceptable standards at Fitzsimons. In response to Complainant's assertion that low staff levels were directly related to an increase in resident falls, he had asked Jan Connor to check records. She had done so and had "reported no consistent increase in falls due to staffing patterns. If you are interested in having copies of her reports, she would be happy to share them with you."

C. Lunch and breaks. Honl indicated that he would discuss the matter of lunch breaks with supervisors and said he expected "that a schedule be arranged so that everyone is provided with lunch breaks away from the work area." He also

stated it was Complainant's responsibility to arrange her duties in order to schedule at least a half hour for lunch. Regarding breaks, he noted that staff gather to chat and relax several times during the day.

D. Medication. Honl had been informed of the incident regarding the erroneous administration of medication by a family member; there was no adverse effect to the resident; appropriate measures were taken for the oversight.

E. Sleeping on the Job. Honl indicated that he had asked Complainant for the name of the individual sleeping on the job and to whom she had reported it. He had spoken to that supervisor and she had not recalled such a report from Complainant.

F. Wrong Treatment. At the March 25 meeting, Complainant had informed Honl that another employee had wrapped a wound which should have been left unwrapped. He had indicated that the incident had been reported, investigated and appropriate measures had been taken. At the meeting, Complainant stated she did not know if the problem was continuing.

G. Night Shift issues. Honl stated that residents are given a choice of when to take a bath as a matter of personal dignity. He also stated that the taking of vital signs "is an operational issue best managed by your supervisor."

H. Orders. At the March 25 meeting, Complainant stated that Lynette had told her about this problem. Honl indicated that "perhaps it would be better to talk to Lynette."

I. Language. Complainant had indicated that residents were upset that so much Spanish was being spoken on the floor and in the dining room. Honl stated that he had addressed this issue through supervisors, and that English was the only acceptable language spoken in the facility unless a resident was a participant in the conversation in a different language. Honl also stated he had not been informed of any problems in the delivery of patient care based on a language barrier.

J. Dietary. Complainant had expressed concern that residents became upset when cleaning staff cleaned up their table before they had finished eating. Honl had responded by explaining that "about two or three weeks ago, a new procedure has been established where the staff are allowed to clean the tables but not the table where a resident is still eating." He also noted that he would discuss her concern about a food service worker recently yelling at an aide with the supervisor.

K. Discrimination. Honl stated that the conduct of the Assistant Director of Nursing described by Complainant as intimidating and rude did not constitute unlawful

discrimination. However, he indicated that he would discuss it with the Assistant Director of Nursing and her supervisor.

L. Gowns. Honl explained that the issue of gowns was another issue for "Lee."

M. Cooperation between Shifts. Honl stated that the lack of cooperation between shifts and equitable distribution of tasks was an issue to be discussed with the Director of Nursing and "Lee."

28. A Performance Improvement Committee of Fitzsimons leaders meets monthly. According to the Minutes of the April meeting, which covered the month of March, under Infection Control, there were 40 infections in March, an increase of 13 over February. Five of the infections treated were C-Diff. The Analysis section indicated, "C-diff was prevalent in March and we put a plan into place – all staff educated [on March 19]." In addition, doctors were educated on how certain antibiotics make residents more susceptible to C-diff.

29. The April 2008 Minutes also reported that there were a total of 39 medication errors for the month of March, "Omissions being number one."

March 31, 2008 Email from Terry O'Neill to HR Director

30. On March 31, 2008, Complainant's husband, Terry O'Neill, wrote an email to Brad Mallon, Director of Human Resources for Respondent. The email informed Mallon that Complainant was being retaliated against for bringing "some concerns about patient care and nursing practice problems to the attention of superiors." He stated that Complainant had "been made aware that there is some criminal activity that has been occurring for some time and that a number of employees believe that this is happening with the knowledge and tacit approval of higher authorities." He indicated that Complainant had "told the DON about what she has been told," and that the DON "has assured Judy that she will do the right thing and bring this to Honl's attention even though she believes that he and other superiors have knowledge about these activities."

31. O'Neill stated that as a representative of the American Legion it was his responsibility to expose criminal acts and improprieties that directly relate to programs that involve funding for veteran related benefits.

32. O'Neill closed his email, "What some despicable individuals have done must be dealt with in a way that will not destroy public perception of the Veterans Homes. I will allow you and other authorities a fair chance to clean up existing problems at the facility before I make a decision to go further. Take my advice and act decisively before this all goes to hell and no one can contain the damage."

33. On April 1, 2008, Mallon forwarded O'Neill's email to Viki Manley, Director of the Office of State and Veterans Nursing Homes for DHS. He indicated that O'Neill was

the husband of a Fitzsimons nurse who had recently received a corrective action, which may have triggered allegations of wrongdoing against the facility. He indicated that he had encouraged the O'Neills to meet with Honl to discuss the issues so that they could be resolved. He informed Manley that it appeared the O'Neills might intend to report the allegations to the State Personnel Board and to the media.

34. Manley immediately responded, "What are the allegations?"

35. On April 2, 2008, SaBell provided Complainant with a grievance form and the grievance procedure rules.

36. On April 7, 2008, Mr. O'Neill emailed Mallon, indicating that O'Neill had received "information from facility staff about additional criminal activity and patient assaults." O'Neill requested "concrete assurance" that action would be taken to address the most serious deficiencies, and stated that if he did not receive such assurance by April 15, he would "take appropriate action" in another venue.

37. In early April 2008, Mr. O'Neill called Manley on the telephone. Manley asked for specific actionable information regarding problems at Fitzsimons. O'Neill stated that a resident had been hit on the head by an LPN, and that the same LPN had engaged in sexual harassment of some female staff.

April 15, 2008 Email from O'Neill to Manley Regarding Warner and Patient L.L.

38. After this telephone conversation with Manley, on April 15, 2008, Mr. O'Neill had an email exchange with her. His first email to Manley indicated that he was attempting to be supportive of his wife by helping her expose problems with patient care and nursing practices. He stated that for years he had served as a veterans advocate, and that he viewed his wife's work at Fitzsimons with pride. He stated, "Judy and I have been overwhelmed with information and statements about a myriad of activities, involving a range of reported criminal activities, impropriety, patient and resident assault and abuse, and other less serious deficiencies and actions." O'Neill requested guidance from Manley as to how to proceed.

39. Manley responded almost immediately, stating, "Mr. O'Neill – I sincerely appreciate your position and willingness to bring abuses to light. Because any personnel discussions should take place with the AG's Office I am not able to delve into those, but I am requesting from you specific resident names and incidences of alleged abuse so that those can be investigated immediately. I will make sure any incident is investigated fully and reported to all reporting bodies if validated."

40. Mr. O'Neill responded that afternoon, stating, "As I understand your Email, you want me to provide you with actionable information regarding matters that pertain directly and specifically to assault and abuse against facility patients and residents." He stated, "there have been reports of extreme disrespect and verbal abuse of patients and

residents that are commonly known to have been concealed or disregarded by facility higher authorities. For example, it is commonly known that for some time LPN Gary Warner has engaged in a continuous and consistent pattern of abuse, often extreme in nature, with the knowledge of Administration. One particular incident involved Warner's assault of a vulnerable patient with whom he had become angry and frustrated. Supervisors have confirmed that the assault was witnessed and reported to Administration. This specific incident involved Warner striking patient [LL] on the head."

41. Mr. O'Neill gave the full name of the patient L.L. whom Warner had allegedly abused.

42. O'Neill stated that supervisors were frustrated over Warner being permitted to work and interact with patients as Charge Nurse while unsupervised and unmonitored. He also stated, "Administration has elected to defer corrective action and prevent unwanted disclosure until after the annual VA [Veterans Administration] survey (being conducted this week)."

43. O'Neill stated that Warner had been reported by staff for "repeated sexual harassment against female staff, and for being extremely inappropriate and verbally abusive. Judy and other staff members have repeatedly made clear that they are willing and ready to provide all pertinent information and statements, provided that sufficient procedures and protections are in place to prevent retaliation against those who cooperate in any investigation."

Manley Response to O'Neill Email

44. Upon receipt of this email from O'Neill, Manley was concerned about two things: the allegations of patient assault and abuse against LL by Warner, and the fact that O'Neill was in possession of protected health information regarding a Fitzsimons resident, in apparent violation of HIPAA.

45. Manley forwarded the email regarding Warner's mistreatment of L.L. to Honl on April 15, 2008, stating, "This allegation needs a full investigation immediately. Please call me."

46. In addition, Manley ordered Honl to look into the apparent breach of patient confidentiality which led to Mr. O'Neill's awareness of LL.'s name and information relating to his care at Fitzsimons.

47. Honl immediately forwarded the email to Leslie Schwartz, HIPAA Compliance Officer and Health Information Management Administrator for Fitzsimons, and Kathrine Foo, HIPAA Privacy and Security Officer at DHS.

48. Honl informed Manley he was aware of an allegation regarding Warner's treatment of LL, and stated he would initiate an investigation immediately.

49. Honl had previously been made aware that the son of patient LL had filed a Complaint Report on March 17, 2008 regarding Warner's treatment of LL.

Background of Complaint Regarding Warner's Treatment of LL

50. On March 17, 2008, a Fitzsimons social worker, Bernie Leksander, met with Jim L., who was the son of Fitzsimons resident LL. Jim was concerned about LPN Warner's treatment of his father a few weeks prior. Leksander filled out a Complaint Report Form based on Jim's statements.

51. The report indicated that approximately three weeks ago, Jim arrived to take his father to lunch on a Saturday. When Jim advised Warner of this, Warner stated, "I need to hear it from him." Jim reported that his father had been very quiet that day and did not immediately answer, due to word-finding problems. When the resident still did not respond, Warner "cocked his finger back 'like a bully would do' and tapped his Dad to get a response."

52. The report indicated that Jim asked Leksander to do whatever she thought was appropriate with this information. She referred it to the Unit Manager, Suzanne Busboom, on March 17, 2008.

53. Busboom contacted Jim and expressed her apology for the behavior of Mr. Warner. Jim did not indicate that he felt his father had been assaulted or abused by anyone at Fitzsimons. Busboom also discussed the concerns with Warner, who denied any recollection of the incidents mentioned by Jim L.

54. On March 26, 2008, Busboom completed Part III of the report, noting her discussion of the incident with Warner and his denial of any memory of it. Warner wrote a statement which was attached to the report, which said in part, "I do understand that people perceive things differently and if this is the case I apologize."

55. Busboom also noted in Part III that she had informed Jim that the incident had been turned in to Fitzsimons Administrator Honl and Madline SaBell, on the direction of the Director of Nursing, that the outcome was pending, and that he would be advised of the final outcome.

56. On April 22, 2008, O'Neill emailed Manley, informing her that Fitzsimons staff had contacted him about their concerns that Warner was still working directly with residents without any monitoring. He informed her, "I have told them that I have been in contact with higher authorities and that they can feel comfortable that all appropriate measures are in place to ensure that Warner cannot assault or abuse patients and residents or present any further potential threat. I hope that I am right in providing such assurance. . . The environment within the facility must be restored to a level where people can again feel comfortable and secure."

57. On April 22, 2008, Honl emailed a staff member at the Colorado Department of Health and Environment regarding Mr. O'Neill's allegations. Titled, "Unfounded allegations at Fitzsimons," the email stated in part, "I have received several emails from a husband of a Fitzsimons employee alleging theft and abuse within the facility. He has even taken his comments to Michael Scott of the AG's office. When pressed for more specific information, he was unable to provide specific details that would allow the facility to pursue further investigation of his allegations." Honl noted that on April 15, 2008, Mr. O'Neill had provided "a name and an incident from which to launch an investigation. The alleged incident involves a LPN and a male resident. The incident in question was brought to the facility's attention by the resident's son who was present at the time of the incident." Honl then described the incident. He also noted that the husband had started to communicate after his wife had received a corrective action, which she was appealing. He stated, "The general performance of the employee has been acceptable."

58. On April 24, 2008, Complainant wrote an email to Honl and copied Manley. She discussed her concerns about a patient recently admitted to Fitzsimons who then began to exhibit C-Diff symptoms. And, she informed him of her discussions with other individuals regarding her perception that the room to which this patient was assigned had never been properly sanitized. She pointed out that the two isolation rooms were carpeted, which made them difficult if not impossible to sanitize.

Investigation of Assault, Abuse, etc.

59. Honl ordered SaBell to conduct a full investigation into the allegations raised in Terry O'Neill's April 15, 2008 email to Manley. The three main issues raised were: assault and abuse; concealing evidence from VA surveyors; and sexual harassment. SaBell interviewed eleven individuals and on May 7, 2008 issued a five-page, single spaced report.

60. SaBell spoke first to the resident's son, Jim. Jim reported to SaBell that there were three separate incidents in which Warner was disrespectful to his father. The first occurred in late February 2008 when he and his father were leaving for lunch. Warner stated, "I want to hear it from your father." Jim questioned whether Warner was serious, and he stated that he was. Jim said that because his father was having difficulty speaking on that day, it was unnecessary to make that type of demand of his father.

61. The second incident occurred approximately three weeks later. Jim L. reported that Warner stood behind his father and "snapped his finger against his ear." When asked if Warner had hurt his father, Jim said that it did not hurt him and it was "more like taunting." He said that Warner's conduct was disrespectful.

62. The third incident occurred on the day his father was dying. Warner stated to Jim, in the presence of his father, "When someone dies, the coloring in their feet changes." He then showed Jim what was happening as his father was dying. Jim said to Warner,

"Don't talk about that now."

63. Jim informed SaBell that these incidents indicated to him that Warner is insensitive and lacks respect for the elderly. He also stated that with this exception, the staff at Fitzsimons was wonderful and he had no reason to believe that his father was abused or harmed physically.

64. At the time SaBell interviewed Jim, his father, L.L., had died.

65. SaBell interviewed Warner, who denied ever having struck LL at any time. He stated that his comment about LL's legs was in response to a question asked by Jim, and admitted having discussed the skin discoloration process with Jim in front of L.L. He denied having engaged in sexual harassment.

66. Unit Manager Kathy Vance informed SaBell that she and another supervisor, Ms. Benjamin, had interviewed Warner and four other nurses individually on April 16, 2008 concerning the allegations of sexual harassment. None of the witnesses corroborated any allegations of sexual harassment.

67. SaBell asked the nursing supervisor if there were other complaints against Warner, including complaints about patient care and sexual harassment against the other nurses. SaBell was informed that there were not.

68. The social worker, Ms. Busboom, reported that she had received no other reports against Warner from family members, and that in fact Warner was popular with the families and residents in general. Other nursing personnel confirmed this general impression, and even stated that since many nurses were not fond of Warner personally, it was more likely that they would come forward to report him for any inappropriate conduct towards residents.

69. Busboom referred SaBell to the family member of a resident, whom SaBell interviewed. This individual stated that Warner was their favorite nurse, had great rapport with her father, gave the family greater detail regarding their father's condition in his telephone reports to family members, and had been present when their father died.

70. To the extent SaBell received any negative information regarding Warner's nursing performance, the interviews revealed that his medication passing and charting were areas of concern.

71. On April 30, 2008, SaBell sent an email to Complainant requesting to speak with her. SaBell stated in the email, "Please consider this as a request for any information you may have regarding sexual harassment, assault and or abuse of resident and any other concerns you and or your husband may have about this facility. Please call me at extension 6449 or provide me with a written statement regarding this matter. I will be at Fitzsimons today, tomorrow and Tuesday, Wednesday and Thursday of next week. Again,

thank you for your assistance."

72. SaBell contacted Complainant again on May 6, 2008 to request information regarding Warner and any other information she sought to share regarding problems at Fitzsimons. Complainant asked if she would be in the office the next day; SaBell stated she would. Complainant said she would discuss it with SaBell the next day.

73. Complainant did not call or visit SaBell at any time during her investigation and did not provide information to corroborate her husband's complaint.

74. SaBell's May 7 report concluded:

- There was "no evidence of assault or abuse by Warner against anyone. The incident was reported and well documented prior to Mr. O'Neill's allegations. The son of resident L.L. himself stated that the incident was NOT assault or abuse nor did Mr. Warner 'strike' his father. He described the incident as 'disrespectful'. No supervisor corroborated the allegations."

- There was no evidence supporting the allegation of sexual harassment.

- Regarding the assertion that information concerning the assault and staffing had been concealed from VA surveyors, SaBell noted that Warner's corrective action resulting from his treatment of L.L. was in his personnel file, and that Warner had been terminated for poor performance relating to documentation on May 2, 2008. She stated that incident reports are reviewed by the surveyors, and the surveyors have access to any and all files they request, including personnel files.

Investigation of HIPAA Violation

75. As indicated above, when Honl received a copy of Mr. O'Neill's April 15, 2008 email to Manley containing the full patient name of L.L. and information regarding his care, he forwarded the email to Leslie Schwartz, Fitzsimons HIPAA Compliance Officer. In this position, Schwartz is responsible not only for compliance but for all staff training in HIPAA regulations.

76. Upon receipt of the email, Schwartz identified two HIPAA violations: disclosures of the resident's name and of the incident involving Warner.

77. On April 28, 2008, Schwartz went to talk to Complainant about the email. She knew Complainant through work and they had a good relationship. Schwartz showed Complainant the email and asked her if she knew anything about it. Complainant said, "Yes." Schwartz asked if Complainant was married to Terry O'Neill, and Complainant responded, "Yes." Schwartz then explained that the information in the email was Protected Health Information which could not be disclosed except to those with a legal connection to

the patient.

78. Schwartz asked if Terry O'Neill had any legal connection to the resident, L.L. Complainant responded that he is a veteran's advocate. Schwartz asked if O'Neill had a legal power of attorney or medical durable power of attorney for L.L. Complainant stated there was none.

79. Complainant stated that she didn't realize that releasing the resident name would be a HIPAA violation. Schwartz explained that under HIPAA mandate, Schwartz had no discretion over the imposition of sanctions and would have to sanction her, because Complainant had been trained in HIPAA compliance. Complainant then stated that others at Fitzsimons had provided the information to O'Neill regarding L.L. Schwartz asked Complainant how he would have gotten the information; Complainant responded that Schwartz would have to ask O'Neill.

80. On April 28, 2008, Complainant sent an email to Manley, stating that she hoped she was not placing herself in jeopardy "by reporting serious problems at Fitz. But, "my husband keeps reminding me that if being complicit in concealing conditions that place patients and residents at substantial unnecessary risk is a condition of continued employment, this is surely not the job for me."

81. Complainant then stated she had been approached that morning by a staff member to advise her "that I am said to have been responsible for HIPAA violations. This is not good!!!! The threat of being charged with a HIPAA violation is terrifying to me. I am asking you to confront whoever is spreading these threats and rumors among staff and stop this. I have acted only in the interests of what is best for patients and residents and the facility. I have not gone outside the DHS reporting structure and the name of a patient assaulted and abused has only been revealed to you in compliance with your request for related information necessary to afford adequate compliance."

82. Complainant also updated Manley on her efforts to assure the appropriate sanitation of resident rooms and the kitchen.

83. Following the April 28 meeting with Complainant, Mr. O'Neill called Schwarz to inquire about their meeting. Schwartz asked O'Neill how he had obtained the information pertaining to L.L contained in his April 15, 2008 email to Manley. O'Neill refused to answer the question. She asked him what his relationship to Fitzsimons was, and he confirmed that he was a veteran's advocate. She asked him to provide written verification of his status as a veterans advocate, but he did not do so.

84. During the week of April 28, 2008, Terry O'Neill also called Ms. Foo and they spoke at length. Ms. Foo asked Mr. O'Neill for all of the details regarding how and from whom he learned about resident L.L. Mr. O'Neill indicated that because he was known as a veterans' advocate at Fitzsimons, many staff members came to him to advise him about problems with resident care. Several staff had informed him about Warner's mistreatment

of LL.

85. At this point Ms. Foo became very concerned about the apparent widespread nature of PHI breaches among Fitzsimons staff. She explained to Mr. O'Neill that under HIPAA, she was required to conduct a training of the entire staff of approximately 250 at Fitzsimons, which would be time consuming and expensive, unless Mr. O'Neill could help her by narrowing the field of who had breached the PHI. Foo asked him to either identify individuals by name, or to provide the name of a unit where the information had originated. If the source of information was from only one unit, she could re-train just that unit.

86. Ms. Foo explained that if the disclosure had been merely "incidental," if would not have been a serious PHI breach. In addition, she promised Mr. O'Neill that she would treat the information as confidential and would simply conduct individual re-training sessions with any individuals he identified.

87. Mr. O'Neill did not provide Ms. Foo with any information that would narrow the scope of her required retraining to the entire Fitzsimons staff. She asked him to discuss it with Complainant and then contact her, if he changed his mind.

88. Approximately one week later, Mr. O'Neill contacted Ms. Foo and informed her that he had disclosed the name of the individual who had disclosed L.L.'s name and information to him, to the Colorado Department of Public Health and Environment. Ms. Foo followed up in an attempt to confirm this by contacting a staff member she knew; however, she was unable to do so.

89. Foo and Schwartz discussed the situation and determined that because the source of the breach could not be confirmed, Schwartz was mandated by HIPAA in this situation to re-train the entire staff of Fitzsimmons, consisting of approximately 250 employees. This re-training would consist of ten separate sessions.

90. With regard to Complainant, Schwartz and Foo both believed that the only reasonable inference to be drawn from the situation was that Complainant had informed her husband about L.L.

91. Complainant informed her husband about LL and Warner's mistreatment of him because she was upset about what she felt was a lack of appropriate managerial response to the incident.

HIPAA Sanction Letter

92. On April 29, 2008, Schwartz issued a "HIPAA Violation" sanction letter to Complainant. The letter began with a summary of the conversation with Complainant on April 28, 2008, stating in part that Complainant "said she didn't know releasing the resident name would be a HIPAA violation, even though [she] had previously taken the HIPAA Privacy and Security Trainings."

93. The letter stated, "Due to the nature of the HIPAA violation and with the additional information received from Terry O'Neill, it is imperative to mitigate any other violations of privacy and security and therefore, all staff will be retrained in HIPAA Privacy and Security with additional State Cyber Security training, which will take place at the same time."

94. In the letter, Schwartz noted that she had initially given Complainant the choice of deciding between two sanctions: either assist with all ten staff HIPAA training sessions or forfeit one day of pay.

95. The letter indicated that the final decision of Ms. Foo was to impose the sanction of requiring Complainant to assist with three of the ten training sessions. Complainant was given the choice of which sessions to assist with.

Complainant's Grievance of HIPAA Sanction Letter

96. On May 6, 2008, Complainant filed a grievance of the HIPAA sanction letter. On the same day, SaBell emailed Complainant to advise her of the steps in the grievance process and how to obtain the grievance rules, forms, and other information.

97. Complainant's written grievance asserted that she was being retaliated against. The grievance states, "I have never disclosed confidential information about any patient to anyone." In addition, it states, "The letter that I have been provided indicates the report of HIPAA violation was made by an individual about whom I have provided whistleblower information. I have yet to receive any assistance dealing with the stress & pressure caused by the retaliation against me."

98. Complainant requested as relief "cessation of retaliation and continued pursuit of baseless personnel actions."

99. On May 6, 2008, Ms. Foo, Ms. Schwartz, and Complainant informally discussed Complainant's grievance. At the meeting, they asked Complainant if she had inadvertently released the resident information to her husband. Complainant denied having done so. When asked how he had gotten the information about L.L., Complainant again responded that they would have to ask Terry.

100. Both Foo and Schwartz had already spoken to Mr. O'Neill the previous week and had asked him the source of the information about L.L. He had repeatedly refused to disclose any individual, stating that it was Fitzsimons "staff."

101. Complainant asked why she was being singled out for the HIPAA violation. They explained to her that her physical proximity and close relationship to Mr. O'Neill, her spouse, led to a reasonable inference that she was the source of the PHI breach.

102. At the meeting, Foo gave an overview of HIPAA regulations, how they impact facilities such as Fitzsimons, and the mandate that facilities must impose sanctions when a breach of PHI occurs.

103. On May 13, 2008, Schwartz issued the letter denying Complainant's grievance. The letter noted that the sanction of assisting with three training sessions was "not retaliation; this is a remediation of a violation of a federally mandated law," required of Fitzsimons.

104. Complainant grieved the decision to Step 2. In this grievance, she stated, "Let there be no misunderstanding or confusion about the basis for this action against me. The action was initiated by an individual about whom I have provided protected whistleblower information as a means to impose further retaliation through a surrogate so that he could avoid exposure and personal responsibility."

105. On May 28, 2008, Honl sent a letter to Complainant informing her that he had convened a panel to hear her grievance on June 4, 2008 at 12:30.

Step 2 Grievance Panel Meeting, June 4, 2008

106. The Step 2 grievance panel consisted of three individuals with expertise in HIPAA privacy issues or human resources. Justin White was the Information Security Officer for the Colorado Department of Health Care Policy and Financing. Heidi Dineen, Assistant Attorney General in the Colorado Office of the Attorney General, is a HIPAA privacy expert in that office. Cristina Valencia was Director of Human Resources for the Colorado Department of Transportation.

107. In addition to Complainant, Terry O'Neill, and the three panel members, Ms. Foo and Ms. Schwartz attended the meeting in order to answer questions from panel members.

108. The meeting lasted for two hours, including two lengthy breaks. It was tape recorded and the recording was admitted into evidence.

109. Each of the panel members entered the meeting with no information regarding Complainant, her employment history at DHS, the April HIPAA sanction letter, or Complainant's grievance of the letter. The panel members approached the fact finding meeting and rendered their decision in an objective manner.

110. A significant portion of the meeting was dedicated to the panel members' acquisition of information regarding the circumstances leading to the HIPAA sanction letter.

111. Panel members asked for the identity of the individual about whom Complainant had allegedly disclosed protected information under the whistleblower act, and who had allegedly initiated the HIPAA sanction letter against her. Complainant did not

identify a specific individual.

112. Panel members asked Complainant what she had told Terry O'Neil which led to his April 15, 2008 email to Manley. Complainant stated that approximately one week before O'Neill wrote that email, she had informed him about a patient having been struck by an LPN, and had also discussed general concerns about patient care at Fitzsimons. She denied having used L.L.'s name with Mr. O'Neill. When asked whether she had also reported her concerns to supervisors, Complainant stated that her supervisors were also concerned about Warner's conduct.

113. Panel members asked if Complainant had reported her concerns to anyone else, and Mr. O'Neil advised her not to answer. He then stated, as Complainant's representative, that he had been reporting allegations of abuse and inappropriate behavior by nursing staff to "outside regulatory agencies" for a period of two months.

114. During the meeting, Complainant indicated that she had reported her concerns about patient care issues at Fitzsimons to the Director of Nursing, Frances Holliday, for approximately one year. She said that she reported concerns orally and in writing. She described her concerns as involving poor infection control and staffing issues, but did not provide any details. She also stated that she had met with the DHS Human Resources Director, Mr. Mallon, in March 2008, to discuss those concerns.

115. Panel members asked Complainant for all instances of retaliation since she had expressed her concerns about Fitzsimons to managers there. Complainant stated that she felt the February 2008 Corrective Action had been retaliation for her complaints made to Ms. Holliday, because out of the four staff members involved in the incident giving rise to the Corrective Action, two others had been placed on education memos and one received no consequence; Complainant was the only one who received a Corrective Action.

116. Complainant became upset during the discussion of the Corrective Action and was given a break. Upon their return to the meeting, she and her husband indicated they had not come to the meeting prepared to discuss the Corrective Action; therefore, the Corrective Action was never fully discussed.

117. Complainant said that she believed the April 2008 HIPAA sanction letter was retaliation for her complaints. Panel members then asked Foo and Schwartz to describe their fact finding process and how they reached their decision to issue the sanction letter. Foo described all of her conversations with Complainant and Mr. O'Neill, including O'Neill's assertion that several staff confided in him because of his status as a veterans advocate. Foo related her concerns about the broad nature of the HIPAA violations occurring among Fitzsimons staff, and described her attempts to have Mr. O'Neill narrow the source of the PHI breach to specific individuals or one unit at Fitzsimons, in order to mitigate the cost of HIPAA training. Foo clarified that she was not in the chain of command at Fitzsimons and therefore did not report to Honl or any other manager there. In addition, Foo had been unaware of Complainant's February 2008 Corrective Action until the June 4, 2008 Step 2

grievance meeting. Schwartz described all of her conversations with Complainant and O'Neill.

118. At the end of the discussion of their HIPAA investigation, Complainant agreed that under HIPAA, the circumstances presented by Terry O'Neill's April 15, 2008 email to Manley required that Foo and Schwartz conduct an investigation, and that the investigation had been a reasonable one.

119. During the meeting, Mr. O'Neill indicated that it was "common knowledge" among Fitzsimons staff that a patient had been assaulted by an LPN, and that the source of the information about L.L. was a staff member who intended to inform an investigative reporter about the incident. O'Neill stated that he asked the staffer not to come forward in that fashion and let him handle it. He stated that he sought to save Fitzsimons from receiving bad press, because such press was not in Fitzsimons' best interest. Mr. O'Neill stated that he did not know if Fitzsimons recognizes him as a veterans advocate for its patients.

120. Panel members asked Mr. O'Neill why he did not reveal the source of information about L.L. to Foo and Schwartz. He did not answer the question. They asked him if he thought Foo and Schwartz would retaliate against him for disclosing the names of Fitzsimons staff who had told him about L.L. He did not answer that question.

121. Panel members asked Complainant and Mr. O'Neil repeatedly whether there were other acts of retaliation imposed against her at Fitzsimons. Complainant indicated that she was never given a lunch break, and that at previous places of employment, a nurse supervisor would take her keys at lunch time and tell her to go take lunch. At Fitzsimons, no one did that with her; however, Complainant did this for the LPN staff on her shift. After some discussion, participants appeared to agree that as a general matter, LPN's cannot relieve RN's for a lunch break, and often there is no staff available to relieve RN's for lunch. The problem was widespread among RN staff and did not apply only to Complainant. Complainant also stated that although she was docked 30 minutes of pay every day for two 15-minute breaks, she did not always take them.

122. Complainant also mentioned that she felt the meeting itself was retaliatory. Panel members explained that the meeting was in response to her grievance and therefore had been initiated by her.

123. At the end of the meeting, Foo made it clear that the HIPAA sanction she had imposed on Complainant required only that she pick up the tests at the end of three training sessions for Fitzsimons staff. Complainant had thus far refused to assist with those trainings.

124. Dineen gave all meeting participants hand-outs on HIPAA compliance.

Step 2 Grievance Panel Recommendation and Decision

125. On June 12, 2008, the panel issued its written recommendation. It concluded that the HIPAA sanction letter was not retaliatory, and recommended that Mr. O'Neill be banned from the facility "to protect all staff members from making improper disclosures concerning patient care." In addition, the panel stated, "Due to the misinformation circulating among facility staff, staff should have specific training on the federal and state laws governing disclosures of alleged patient abuse, whistleblower disclosures and employment retaliation."

126. On June 16, 2008, Honl issued a three-page final agency grievance decision denying Complainant's grievance of the HIPAA sanction letter. He noted that he had reviewed the Panel's June 12, 2008 recommendation; the HIPAA training materials in Complainant's personnel file; all grievance documents; and other pertinent documents.

127. Honl noted, "As a health care professional, you've been trained that HIPAA only permits disclosures concerning alleged patient abuse to a health oversight agency, law enforcement official, or other entity authorized by law to investigate patient abuse, 45 CFR 164.502 and 512. Because your spouse refused to name the source of private information, this facility was mandated to provide HIPAA training for the entire facility. This was accomplished June 2 through June 10, 2008."

128. Honl noted that on March 25, 2008, Complainant had mentioned the problem with taking breaks. Since that meeting, Complainant and Honl had both discussed the issue with Janet Dauman, Interim Director of Nursing. Dauman and Honl both determined that "as a professional nurse, you are expected to plan your time appropriately if you need to take a break." He also noted that there was no indication that any staff at Fitzsimons had been forbidden from taking breaks. He therefore concluded that there was no evidence of retaliation against Complainant in the form of prohibiting her from taking breaks.

129. Lastly, Honl concluded that Complainant had disclosed private health information to an unauthorized individual, namely, Mr. O'Neill. He therefore sustained the action taken by the HIPAA Compliance Officer. He also stated, "Further, inasmuch as you admitted that the action taken by Ms. Schwartz was reasonable and appropriate, you are directed to comply with the sanction by assisting with HIPAA training for this facility."

130. Honl provided appeal rights to the State Personnel Board. Complainant appealed.

Events During Complainant's June 4, 2008 Shift

131. Kelley Hamm became the new Director of Nursing at Fitzsimons in May 2008. Less than two weeks after her arrival, on June 4, 2008, Complainant was scheduled to participate in the Step 2 Grievance panel meeting.

132. Ms. Hamm knew nothing about the meeting. She was unaware of Complainant's March 25 meeting with Honl, Complainant's expressed concerns about patient care at Fitzsimons, the April 15, 2008 email from Mr. O'Neill to Manley, the HIPAA sanction letter, and the claim of retaliation in Complainant's grievance.

133. On June 4, 2008, at 11:45 a.m., Ms. SaBell approached Hamm in order to inform Hamm of Complainant's planned absence from her shift for the meeting at 12:30 p.m. that day. Hamm immediately talked to Complainant and asked her if she had informed her shift supervisor of her expected absence for the meeting. Complainant said she had not. Hamm asked Complainant to administer all of the 12:00 p.m. medications on Heritage Left prior to leaving the floor, and informed Complainant that Hamm would find a relief nurse to cover Complainant's shift during her absence.

134. At 2:30 p.m. on June 4, the relief nurse went to Hamm to see if Complainant would be out of her meeting soon. The relief nurse informed Hamm that when Complainant had given her report, Complainant stated she had given all 12:00 p.m. medications except the two antibiotics. However, the relief nurse discovered that Complainant had not signed the Medication Administration Record (MAR) to confirm the 12:00 p.m. Lasix order had been given. The nurse needed to talk to Complainant to find out if it had been given.

135. At 3:30 p.m. on June 4, the relief nurse discovered that a second patient, G.F., had a physicians order for 200 mg of Lasix at 12:00 p.m., but that it had not been charted on the MAR as given.

136. Lasix is a diuretic used to drain sodium from the body for the purpose of diluting water and enabling the heart to pump better. A normal dose of Lasix is 20 – 30 mg. G.F. was a patient with heart failure; therefore, the 200 mg dose of Lasix was a very aggressive use of the drug to treat G.F.'s heart condition.

137. It was unsafe to administer G.F. two doses of 200mg of Lasix. Ms. Hamm decided not to give G.F. Lasix at that time.

138. After Complainant's meeting, Hamm inquired about whether she had given the Lasix to the two patients. Complainant stated that she had given the 200mg dose to G.F., but had not given it to R.W.

139. Nursing standards of practice require a nurse to chart administration of all medications on the MAR at the time the medication is given. If a nurse does not sign off on the MAR that he or she has administered an ordered medication, it is assumed that the medication has not been given.

140. Complainant's failure to chart the administration of 200 mg order of Lasix for G.F. constituted a violation of nursing standards of practice, resulting in the potential for another nurse to administer an extra 200 mg dose. If G.F. had been given an extra dose of

200mg of Lasix, it could have resulted in a serious reaction such as cardiac arrest or possible death.

141. Hamm was sufficiently concerned about Complainant's breach of nursing standards in her medication administration practices with G.F. that she informed Honl of the incident.

Resident E.U.

142. Complainant cared for resident E.U. during the month of June 2008. E.H. had skin tears on his lower extremities during June 2008.

143. On June 17, 2008, Amanda Schatz, RN, cared for E.H. Schatz circled, "Skin Tear" on E.U.'s Nursing Data Collection Tool form. She also wrote, "discolored to BLE [bilateral extremities]". On June 18, 2008, Schatz again cared for E.H. She circled "Skin Tear," and wrote "LLE [meaning left lower extremities]" and, "BLE – discolored."

144. Complainant cared for E.U. during her 6:00 a.m. to 6:00 p.m. shift on June 18, 2008. Complainant initialed the Treatment Administration Record indicating she had treated the skin tears. However, Complainant did not enter any charting on E.U.'s medical record to indicate that she had assessed E.U.'s skin tears. On E.U.'s Nursing Data Collection Tool form on that date, Complainant made no notations regarding the skin tear, circling "Normal Pigmentation," "Warm" and "Dry."

145. On June 19, 2008, Schatz again cared for E.H. She checked the "Yes" box under New Concern. She also circled "Skin Tear" and wrote "discolored BLE." The next nurse who cared for E.U. on June 19 circled "Wound", and wrote, "Open wound . . .", and wrote Nurses Notes on the back of the form at 10:00 a.m., "Has open area on his left lower extremity. Dressing changed. The wound . . . . oozing serous fluid. The leg is still swollen. Has edema on bilateral lower extremities but refused to elevate the feet. Closely monitored to prevent falls."

146. The day shift nurse on June 20 who cared for E.U. charted, "Stasis wounds on left lower extremities" at 8:00 a.m. on the Nursing Data Collection notes and charted nurses notes including, "Lower extremities on the left he has a venous wound which is oozing serous fluid," adding that she had drained it and placed dry dressing on it. She also charted that both the chair and bed alarms were in place and that the patient was instructed not to move without assistance.

147. On June 21, 2008, nurse Schatz noted no new concerns, and wrote, "Skin tear reopened, discolored to BLE." She also charted nurses notes that the patient continued to refuse leg rests, and that she had massaged the left leg.

148. Complainant was off work on June 19 and 20, 2008.

149. Upon her return to work on June 21, 2008, at 6:00 a.m., Complainant was assigned to care for E.U. At 7:30 a.m., E.U. fell out of bed during Complainant's shift while she was out of the room. In response to the fall, Complainant appropriately filled out an incident report and notified the physician of the fall.

150. In addition, Complainant charted E.U.'s fall in the nurses notes section on the back of the form, "Patient noted to be sitting upright on floor beside bed when writer called to room. CNA reportedly had removed mattresses from beside bed in preparation of getting patient dressed. Patient sitting on edge of bed, leaned to reach shirt, and slid to floor. CNA not with patient at time, had gone to bathroom. No injuries noted; Dr. Ragsdale notified by message machine, daughter also notified by writer. Neuro checks started . . . Patient reminded to always call for assistance with ADL's [activities of daily living]."

151. If no nursing personnel are present at the time a resident falls, it is impossible to know where any potential injury may have occurred. The standard of care for a nurse caring for a patient who had experienced an unwitnessed fall is: close monitoring and assessment of the patient's clinical state for the next 72 hours, with a focus on evidence of possible head injury, bruising, or other type of internal injury resulting from the fall.

152. In addition, because E.U. was a patient on Coumadin, a blood thinner, the standard of nursing care required Complainant to closely monitor E.U. for bruising, because the Coumadin would decrease his body's ability to clot.

153. Complainant performed no charting in E.U.'s chart for the remaining ten hours of her shift until 6 p.m. Therefore, there is no evidence that she closely monitored or assessed the resident for injuries or bruising from the fall. In addition, Complainant did not assess, measure or describe E.U.'s wounds in the nurses' assessment.

154. At 6:00 p.m. on June 21, 2008, when Complainant completed her shift and gave the report to the oncoming nurse, RN Schatz, Complainant did not report any bruising on E.U.'s body.

155. E.U. complained of pain to Schatz during the evening of June 21, 2008. At approximately 10:00 p.m., Schatz lifted up E.U.'s pajama top slightly and found bruising. In the course of examining the bruise, she discovered that it was enormous in size, running from his hip upward through the entire right side of his body, spread through his abdomen and back to his flank. The bruise was red and purple in color, indicating that it was new. Older bruises turn green and yellow prior to fading.

156. Schatz notified Hamm of the bruise and Hamm immediately went to observe the bruise. Hamm observed that the bruising covered the patient's entire right side and indicated bleeding spread through a large area in the tissues. Hamm looked at E.U's chart and discovered he had fallen out of bed the previous morning.

157. Hamm was shocked to find there was no charting for the remainder of the

day shift on June 21, 2008, after his 7:30 a.m. fall. She concluded that Complainant had failed to monitor or assess E.U. for the ten-hour period following his fall

158. Schatz filled out an Incident Report on the bruising, informed the physician, applied ice packs, gave Tylenol, and implemented an order for X-rays.

159. Hamm was sufficiently concerned about Complainant's failure to closely monitor E.U. after his fall that she notified Honl about it.

160. On June 22, 2008, Complainant cared for E.U. during her 6:00 a.m. to 6:00 p.m. shift. She charted in the nurses notes that the nurse aide and E.U. reported the bruise was old, he had had it "for a while," and he denied any pain or discomfort.

161. Complainant did not make any charting entries containing an assessment of E.U.'s bruising, his clinical condition, or his skins tears on his lower extremities, during her June 22 shift.

162. Schatz cared for E. U. on the next shift, starting at 6:00 p.m. During her shift, at 1:00 a.m. on June 23, Schatz charted in the nurses notes, "no improvement noted to stasis ulcers/ST [skin tears] to LLE." E.U.'s skin tears had degenerated into stasis ulcers.

163. A stasis ulcer is a wound that has become non-healing because blood is no longer flowing to it; hence it is in stasis. Assessment of a stasis ulcer requires that measurements be taken and a description of the wound be charted, so that it can be monitored for infection.

164. On June 23, 2008, E.U. was transferred from acute care to the long term unit, the Constitution Unit. On that day, the Unit Manager came to Ms. Hamm and said, "Kelley, you told me this patient was doing getter." She informed Hamm that E.U. had eight stasis ulcers.

165. Hamm examined the charting for E.U. in order to find out if any of the nurses previously caring for E.U. had discovered the stasis ulcer. She noted that on June 20 and June 23, 2008, two nurses had charted the wound as stasis ulcers.

166. Hamm reviewed all of the charting of E.U.'s skin tears for the prior few weeks and discovered that Complainant and one other nurse had failed to make any charting entries describing, measuring, or assessing his skin tears or their degeneration into stasis ulcers.

167. Hamm pulled the personnel file of the other nurse and discovered one prior educational memo on the issue of absenteeism. Because it was this nurse's first offense in terms of a violation of nursing standards of practice, Hamm performed an educational inservice on documenting, treating, and measuring stasis ulcers and non-healing skin tears with that nurse and placed an educational memo in her file.

168. Hamm mentioned her concerns about Complainant's failure to assess and chart E.U.'s wounds to Honl.

July 7, 2008

169. Fitzsimons has a policy governing patients that are taking Coumadin, a blood thinner. Such patients' blood coagulation level, also known as the "INR" [International Normalized Ratio] is to be tested on a routine basis. A high coagulation level of 3.5 or above means that a person's blood is coagulating slowly and that the individual could bleed excessively in the head or in the event of a cut. The policy requires any nurse caring for a patient with 3.5 or above to "notify physician/designee and order a STAT lab draw per facility protocol." The second blood draw is performed with a needle into the vein instead of a finger prick, and thereby assures accuracy of the coagulation level.

170. The INR policy was finalized in December 2007. On January 24, 2008, Fitzsimons nursing staff were given an In-Service training session on this policy. Complainant attended the training session.

171. On July 7, 2008, Complainant cared for a patient taking Coumadin who had a coagulation result of 3.5.

172. Complainant did not notify the physician or request a STAT order from a doctor for a blood draw.

173. Another nurse discovered the violation of the INR policy the following day and ordered Complainant to obtain the STAT blood draw. Ultimately, the Assistant Director of Nursing advised Hamm about the violation.

Hamm Review of Complainant's Nursing Care

174. Hamm became very concerned about Complainant's repeated nursing errors during June and July 2008. Hamm reviewed Complainant's personnel file and saw that in February 2008 she had been given a Corrective Action for failing to implement a STAT order which was handed to her by a physician at the end of her shift.

175. Hamm saw a pattern of substandard nursing practice by Complainant. There were enough incidents to bring Complainant's standard of practice as an RN into question.

176. Hamm reviewed the training records and found that Complainant had been recently trained in the standards and protocols she had violated.

177. Hamm found that on January 24, 2008, at the Heritage Left Nurses meeting attended by Complainant and the other nurses, the nurses were all advised and provided a handout of the following Assessments requirement: "We will now be doing assessments

EVERY shift. A head to toe assessment is expected from each of you on your residents that are on Med A, with charting that accurately reflects that."

178. In addition, Hamm found that on January 24 and February 28, 2008, Complainant had received facility-directed education on wound care documentation. The February 28 training materials stated in part, "Daily documentation of wound treatment – Wound site/type of wound (stasis or pressure ulcer, incision, laceration); appearance of wound."

179. Hamm discussed her concerns about Complainant's pattern of substandard nursing practice with Honl and they decided to schedule a pre-disciplinary meeting to discuss the issues.

180. On July 1, 2008, Honl sent a letter noticing a predisciplinary meeting to Complainant, informing her that the matters to be addressed included "you failure to inform your supervisor of your absence on June 8, 2008; failed to document in the M.A.R. the administration of Lasix; and failure to document a resident's leg ulcers."

181. After this letter had been sent, Hamm became aware of Complainant's violation of the INR policy on July 7, 2008. Therefore, on July 7, 2008, a second letter was sent, adding this issue and the failure to report bruising to the list.

182. Complainant requested that the predisciplinary meeting be postponed; her request was granted.

Predisciplinary Meeting

183. On July 21, 2008, Complainant and her husband attended the predisciplinary meeting with Honl and Hamm.

184. Complainant began by stating she had disclosed serious problems with patient safety and welfare at Fitzsimons, and she believed she was being retaliated against for those disclosures. She indicated that others at the nursing home came to her with problems regarding patient care, but not to higher authorities. She expressed frustration with not having been appreciated or respected, and stated she had only been censured and the subject of retaliation.

185. Complainant asked where the list of nursing care issues on the letter noticing the predisciplinary meeting had come from. Hamm responded that it had come from her.

186. Honl then reviewed the contents of State Personnel Board Rule 6-10 in detail.

187. Hamm reviewed each of the five issues of concern. Regarding the June 4 failure to inform her immediate supervisor of her impending absence from her shift, Hamm indicated this was a minor issue in and of itself that would not customarily give rise to

disciplinary action.

188. She then discussed what had occurred on June 4 when the relief nurse came to her for guidance on what to do with the two patients with 12:00 Lasix orders which had not been signed off by Complainant. Complainant stated that she had given the medications but not signed the MAR. Hamm stated that she had decided not to give the 200 mg dose because it would be dangerous to double dose the patient.

189. With regard to Complainant's failure to appropriately chart any assessments of E.U.'s skins tears and stasis ulcers, Honl asked Complainant questions about whether she understood the difference between a skin tear and a stasis ulcer. He asked her what to look for in the assessments. She answered appropriately. When he asked if the nurse is required to obtain measurements of a wound, she responded yes. Complainant discussed the requirements of measuring wounds and the importance of assessing the healing process in order to determine whether a skin tear was progressing into an ulcer. She demonstrated that she knew what was required. In her defense, Complainant stated that she never reviewed the prior nurse's assessments when she assumed care of a patient; instead, she relied on their oral reports. Therefore, charting on the condition of the wound was not necessary.

190. Hamm explained to Complainant that Hamm had been meeting with other nursing staff who cared for E.U. and had failed to meet proper standards of wound assessment and charting.

191. Honl explained that because Complainant had just received a Corrective Action in February 2008 and had been placed on an education plan including assessment practices, the next step was progressive discipline.

192. In the course of discussing Complainant's failure to obtain the STAT blood draw order after the 3.5 INR reading, Ms. Hamm asked Complainant if she was aware of the policy. Complainant did not answer this question. Complainant stated that she had followed the flow sheet, and pointed out that she had made suggestions to modify the flow sheet used for INR readings to add a section integrating the STAT blood draw policy. Hamm responded that she liked the suggestion but it had been rejected by the Fitzsimons medical director.

193. Regarding E.U.'s bruise discovered on June 21, Complainant stated that she had learned about an older looking bruise when she received report on E.U. on June 18, prior to her days off. She stated that when she returned to work on June 21, it was the same old bruise and that she had not charted the bruise on June 21 because it was not new.

194. Complainant was given the opportunity to provide additional information after the predisciplinary meeting. On July 22, 2008, Complainant sent a letter to Hamm. In the letter, Complainant made the following points:

- She was forced to work until 10:15 p.m. after the predisciplinary meeting in order to complete the work on her shift, because no relief nurse had been provided during her attendance;

- At the meeting, Hamm had stated "your contention that any absence to attend a grievance related meeting was unacceptable and that it was solely my personal responsibility to ensure that coverage was arranged during this absence."

- "If it brings you any measure of satisfaction, you can rest assured that your personal feelings were made quite clear and were sufficiently driven home during the more than 16 hours I had to work to complete required duties because I was provided no relief and assistance during my time in the Rule 6-10 meeting that was scheduled and managed by yourself and Brad Honl. You may believe that this time without lunch or breaks clearly drove home your point that there would be adverse and certain costs associated with my grievance appeal activities."

- "I have also come to appreciate that it is foolish to expect that any allegations against me will be based on factual evidence of wrongdoing or substantive deficiency. Here's a thought. Want to see real potential for errors or unintended omissions? Try routinely working twelve and a half hours without lunch and breaks. Or, better yet, more than sixteen hours. But, then I guess that is really the point of the retaliation after all. Being subjected to working in an extremely stressful and demanding environment without benefit of breaks and lunch satisfies several objectives. Create enough unnecessary pressure and stress and not only will I experience vengeance for my whistleblower activities, but I will likely be more prone to error and omission that will be used to justify additional adverse corrective and disciplinary consequences."

Termination Letter

195. Honl concluded that it was not safe to have Complainant continue to practice nursing at Fitzsimmons. In February 2008 she had received a Corrective Action for failing to implement at STAT order, and had been retrained in patient assessments. Despite these actions, Complainant continued to commit errors in her core nursing practices. He felt that due to the risk to patients he could not allow this to continue.

196. On July 28, 2008, Honl sent a letter to Complainant terminating her employment. The letter listed the five issues discussed at the predisciplinary meeting as the basis for her termination. Regarding Complainant's failure on June 4, 2008 to document whether she had administered the 200mg dose of Lasix to the patient with heart trauma, the letter noted, "Due to the lack of a recorded entry, another nurse could easily have given the patient another dose resulting in serious reactions such as cardiac arrest and possible death."

197. Regarding Complainant's failure to "assess, measure or describe the wounds in the nurses' assessment" on her shifts on June 21 or 22, 2008, the letter noted that Complainant had stated at the predisciplinary meeting that she never reviewed the prior nurse's assessments when she assumed care of a patient; instead, she relied on their oral reports. In response, the letter stated, "On January 24, 2008 and on February 28, 2008, you received facility-directed education on wound care documentation that includes the importance of assessing, describing, measuring, and documenting wounds."

198. The last issue was Complainant's failure to follow facility policy on obtaining a STAT order for a blood draw due to a high INR reading. The letter noted that Complainant had been trained in the INR policy on January 24, 2008.

199. The letter indicated that Complainant had not provided mitigating information at the predisciplinary meeting.

200. Complainant did not testify at hearing.

201. Exhibits admitted at hearing revealed to Respondent that Complainant had submitted a copy of her March 25, 2008 list of concerns as a complaint to the Colorado Department of Public Health and Environment on May 8, 2008. On July 18, 2008, the agency rendered its investigative report responding to Complainant's report.1 This fact was unknown to Respondent at the time the HIPAA sanction letter and the termination were imposed.

202. Complainant filed a timely appeal of the disciplinary action with the Board.

DISCUSSION

I. GENERAL

Certified state employees have a property interest in their positions and may only be disciplined for just cause. Colo. Const. Art. 12, §§ 13-15; C.R.S. § 24-50-101, *et seq.*, *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994). Such cause is outlined in State Personnel Board Rule 6-12, 4 CCR 801 and generally includes:

(1) failure to comply with standards of efficient service or competence;
(2) willful misconduct including either a violation of the State Personnel Board's rules or of the rules of the agency of employment;
(3) false statements of fact during the application process for a state position;
(4) willful failure or inability to perform duties assigned; and
(5) final conviction of a felony or any other offense involving moral turpitude.

1 The report found that Warner had treated LL with disrespect but had not committed abuse or assault or mistreatment.

In this *de novo* disciplinary proceeding, the agency has the burden to prove by preponderant evidence that the acts or omissions on which the discipline was based occurred and that just cause warranted the discipline imposed. *Kinchen*, 886 P.2d at 706. The Board may reverse Respondent's decision if the action is found to be arbitrary, capricious or contrary to rule or law. C.R.S. § 24-50-103(6).

II. HEARING ISSUES

A. Complainant committed the acts for which she was disciplined.

Respondent has proven all of the material facts underlying the disciplinary decision. Although not serious, Complainant did not inform her immediate supervisor that she would be absent from the floor during her shift on June 4 while she attended the grievance meeting. While any employee about to enter a meeting regarding a grievance would be nervous, it is a fundamental responsibility of an RN on an acute care unit to inform her supervisor if she is going to be absent during her shift.

Prior to attending the grievance meeting, Complainant was ordered by the Director of Nursing to administer all 12:00 p.m. medications. Complainant placed a resident at risk of a heart attack or death by failing to chart the administration of 200 mg of Lasix. Again, a core nursing function that should be second nature was neglected.

Complainant failed to chart any assessments of E.U.'s skin tears during three shifts in the week preceding their development into stasis ulcers. On January 24 and February 28, 2008, Complainant had been trained in wound care documentation to include assessing, describing, measuring, and documenting wounds. Complainant's repeated failure to assess, describe, measure and document E.U.'s wounds reveals that she was not caring for this resident and constitutes a pattern of violating basic nursing standards of practice.

When E.U. fell at the beginning of Complainant's shift on June 21, 2008, she took responsibility for completing the required Incident Report and notifying the required individuals. However, the medical record demonstrates that she ignored the patient for the remaining ten hours of her shift. Because no one had seen E.U. fall, the location and nature of his potential injuries were unknown. As the RN caring for E.U. that day, it was Complainant's duty to closely monitor E.U. for any signs of a head injury, bruising to his body, or internal injuries. In January of 2008, Complainant had been trained in the Assessments requirement: "We will now be doing assessments EVERY shift. A head to toe assessment is expected from each of you on your residents that are on Med A, with charting that accurately reflects that." Despite the heightened risk of injury to the patient following his fall, Complainant abdicated her duty to aggressively monitor, assess and chart the results thereof in E.U.'s medical record for nearly an entire shift on June 21, 2008.

Complainant knew the policy requiring that she obtain a STAT blood draw order for any patient on Coumadin with a coagulation level of 3.5. Nonetheless, she violated the

policy by failing to arrange for the STAT blood draw during her shift on July 7, 2008.

Complainant did not testify at hearing. Therefore, scant mitigating information concerning the above incidents was offered or admitted into evidence.

B. The Appointing Authority's action was not arbitrary, capricious, or contrary to rule or law.

In determining whether an agency's decision is arbitrary or capricious, a court must determine whether the agency has 1) neglected or refused to use reasonable diligence and care to procure such evidence as it is by law authorized to consider in exercising the discretion vested in it; 2) failed to give candid and honest consideration of the evidence before it on which it is authorized to act in exercising its discretion; 3) exercised its discretion in such manner after a consideration of evidence before it as clearly to indicate that its action is based on conclusions from the evidence such that reasonable men fairly and honestly considering the evidence must reach contrary conclusions. *Lawley v. Department of Higher Education,* 36 P.3d 1239, 1252 (Colo. 2001).

Complainant has not asserted that Respondent's termination or HIPAA sanction letter were imposed in an arbitrary or capricious manner in violation of the *Lawley* standard. Moreover, the evidence demonstrates that Respondent's decision making process did comport with that standard. The agency used diligence and care to obtain all relevant information prior to rendering its decisions, gave candid and honest consideration to the evidence in its possession, and rendered reasonable decisions.

C. Respondent did not violate the State Employee Protection Act

Complainant asserts that her termination and the sanction letter were imposed in violation of the Colorado State Employee Protection Act, also known as the "whistleblower act." This statute protects state employees from retaliation by their appointing authorities or supervisors because of disclosure of information about state agencies' actions which are not in the public interest. *Ward v. Industrial Com'n,* 699 P.2d 960, 966 (Colo. 1985).

The purpose of the Act appears in the Legislative Declaration,

> "The general assembly hereby declares that the people of Colorado are entitled to information about the workings of state government in order to reduce the waste and mismanagement of public funds, to reduce abuses in governmental authority, and to prevent illegal and unethical practices. The general assembly further declares that employees of the state of Colorado are citizens first and have a right and a responsibility to behave as good citizens in our common efforts to provide sound management of governmental affairs. To help achieve these objectives, the general assembly declares that state employees should be encouraged to disclose information on actions of state agencies that are not in the public interest and

that legislation is needed to ensure that any employee making such disclosures shall not be subject to disciplinary measures or harassment by any public official." Section 24-50.5-101, C.R.S.

Complainant bears the burden of proof to establish that her disclosures fell within the protection of the Act and that they were a substantial or motivating factor in the agency's adverse actions taken against her. *Ward v. Industrial Comm'n*, 699 P.2d 960 (Colo. 1985); Section 24-50-103(1), C.R.S. If Complainant meets this burden, Respondent then has the opportunity to establish by a preponderance of the evidence that it would have reached the same decision even in the absence of the protected conduct. *Id.*, 699 P.2d at 968. *See also Taylor v. Regents of University of Colorado*, 179 P.3d 246, 249 – 250 (Colo.App. 2007).

Disclosures

In order to be protected under the Act, a disclosure of information must touch on a matter of public concern. *Ferrel v. Colorado Dept. of Corrections*, 179 P.3d 178, 186 (Colo.App. 2007). The disclosure may be provided in writing or orally. *Ward v. Industrial Commission*, 699 P.2d 960, 967 (Colo. 1985). The Act defines "disclosure of information" as: the "provision of evidence to any person or the testimony before any committee of the general assembly, regarding any action, policy, regulation, practice, or procedure, including, but not limited to, the waste of public funds, abuse of authority, or mismanagement of any state agency." Section 24-50.5-102(2), C.R.S.

Complainant's written and oral statements to Honl at the March 25, 2008 meeting are protected disclosures under the whistleblower act. The memo she gave Honl, on its face, concerns her perception of widespread patient care problems that Fitzsimons management had failed to address, thereby constituting mismanagement and an abuse of their authority as caretakers of the state nursing home residents. If a state nursing home administrator and managers fail to address widespread infection control issues, staffing shortages that result in an increase in patient falls, and other such safety issues, this is a matter of public concern. While Complainant often offered isolated instances of a patient care problem, the entirety of the memo encompasses what could be viewed as widespread mismanagement. *Ferrel, supra.*

Terry O'Neill's April 15, 2008 email to Manley was treated as a communication for which Complainant was responsible. Therefore, for purposes of analysis under the whistleblower act, it is fair to view this email as a communication or disclosure made by Complainant. Mr. O'Neill's email discussed "reports of extreme disrespect and verbal abuse of patients and residents that are commonly known to have been concealed or disregarded by facility higher authorities." He gave as an example LPN Gary Warner's "continuous and consistent pattern of abuse, often extreme in nature, with the knowledge of Administration," and cited Warner's "assault" of L.L. by striking him on the head. He stated that supervisors had reported the incident to Administration and were frustrated that Warner was still working on the floor unsupervised. O'Neill closed his email with the

assertion that the Fitzsimons administration had failed to act in order to evade detection of the problem by the VA surveyors.

The information in the April 15, 2008 email raises serious allegations concerning high level managerial and administrative failure to address patient abuse at Fitzsimons, and alleges a concerted effort to avoid detection by federal oversight authorities. Therefore, it raises issues that are of public concern and qualifies as a protected disclosure under the whistleblower act. *Ferrel, supra.*

The whistleblower act excludes from its protection any disclosures that fall into one of the following three categories:

(a) An employee who discloses information that he knows to be false or who discloses information with disregard for the truth or falsity therein;

(b) An employee who discloses information from public records which are closed to public inspection pursuant to section 24-72-204 [the Open Records Act];

(c) An employee who discloses information which is confidential under any other provision of law.

Section 24-50.5-103(1)(a)-(c), C.R.S.

Mr. O'Neill's April 15 email contains confidential information regarding L.L. under HIPAA. Thus, it could arguably be excluded from whistleblower protection under Subsection 103(1)(c). However, the record does not definitively establish that Complainant should not have possessed PHI regarding L.L. Therefore, the email will be treated as a protected disclosure.

Complainant stated in the Step 2 Grievance Panel meeting that she had made repeated oral and written disclosures about patient care issues to Frances Holliday, the Director of Nursing until at least February of 2008. However, at trial, Complainant introduced no evidence of these disclosures. Therefore, the discussion herein encompasses only the disclosures discussed above.

Substantial or Motivating Factor

Once it is established that protected disclosures occurred, the employee must demonstrate a causal connection between the protected disclosures and the adverse decisions. To do this, Complainant must show that the protected disclosures were "a substantial or motivating factor" in Respondent's decisions to impose the HIPAA sanction letter and to terminate Complainant's employment. *Ward*, 699 P.2d at 968. Section 24-50-103(1), C.R.S.

HIPAA Sanction Letter. Complainant has not met her burden of demonstrating that

the protected disclosures were a substantial or motivating factor in Respondent's issuance of the HIPAA sanction letter. The evidence demonstrates that Foo and Schwartz had no choice but to initiate an investigation into the source of the PHI breach of L.L.'s identity; HIPAA required them to do so. The fact that Manley had actually requested that Mr. O'Neill give her "actionable" information does not vitiate their mandate to investigate the PHI breach. Moreover, the content of the PHI breach (allegation of patient abuse) was irrelevant to their job of enforcing compliance with HIPAA at Fitzsimons.

No evidence supports an inference that Complainant's disclosures were a substantial or motivating factor in the issuance of the HIPAA letter. Once the investigation ensured, the only reasonable conclusion to be drawn was that Complainant was the source of the PHI breach. Foo reported to no one at Fitzsimons and was unaware of Complainant's disclosures to Honl on March 25. Foo's lack of any animus towards Complainant is evinced in her repeated promises to Mr. O'Neill that if he revealed the staff members who had released L.L.'s identity to him, she would guarantee their confidentiality and would retrain them privately.

Foo aggressively sought to protect Complainant from receiving any sanction. Schwartz was also unaware of Complainant's disclosures on March 25 and there is no evidence that she sought to retaliate against Complainant for protected whistleblower activity.

Complainant and her husband's refusal to reveal the source of the information about L.L. forced Schwartz to retrain the entire 250-member Fitzsimons staff. Therefore, the sanction imposed on Complainant under these circumstances, a mere letter in her file and a requirement to assist with three training sessions, was light.

Honl removed himself from the HIPAA issue by appointing a panel of experts to make a recommendation on whether to uphold the HIPAA sanction letter. The panel objectively investigated the situation, spent two hours meeting with Complainant and her husband, and determined that the sanction letter imposed was reasonable and not retaliatory.

No evidence in the record establishes a causal connection between the protected disclosures and the HIPAA sanction letter. Complainant's claim that the letter was imposed in retaliation for protected whistleblower disclosures fails.

Termination. Turning to Complainant's termination, the evidence shows that following the March 25, 2008 meeting and the April 15, 2008 email from Mr. O'Neill to Manley, Fitzsimons and DHS leaders responded quickly and appropriately to the information received. Honl was previously aware of most of the information and had taken steps to rectify the problems identified. In addition, the evidence demonstrates that the new Director of Nursing, Ms. Hamm, was the driving force behind Fitzsimons' decision to discipline Complainant. Hamm was unaware of Complainant's protected disclosures, unaware of the HIPAA sanction letter and events leading to it, and was legitimately

concerned about Complainant's pattern of substandard care. The evidence fails to establish that the protected disclosures were a substantial or motivating factor in Respondent's decision to terminate Complainant's employment.

With regard to the March 25, 2008 meeting with Complainant, Honl was previously aware of and had already acted on most of Complainant's concerns prior to their meeting. On March 13, he had directed the Infection Control Officer at Fitzsimons to address the issue of C-diff in the facility, and Thornton had completed the plan. All Fitzsimons staff had been trained in infection control on March 19, 2008. Doctors had also been trained on tailoring their prescription practices to minimize C-Diff. Honl attached a copy of the C-diff plan to his response letter to Complainant so that she could examine how management was addressing the issue.

Honl was also aware of LPN Warner's mistreatment of L.L. On March 17, 2008, LL's son had made a full report to a Fitzsimons social worker, who initiated a written Complaint Report Form. The report indicated that LL's son asked the social worker to do whatever she thought was appropriate with this information. She investigated the incidents, spoke with Warner, and referred it to the Unit Manager on March 17, 2008. The information then made its way up the chain of command to the Director of Nursing and Honl. According to SaBell's report, Warner received a corrective action resulting from his treatment of L.L. (And, ultimately, Warner was fired for other reasons in May 2008.)

The other serious issue raised by Complainant on March 25 concerned her assertion that low staffing levels of CNA's caused nurses to perform nurse aide functions, resulting in poor patient care and increased resident falls. Notably, she stated at the meeting that current nurse aide levels were appropriate; her concerns appear to have been related to the past. Honl investigated the staffing issue and confirmed that nurse aide staffing levels were within acceptable standards and that Complainant's unit had one RN vacancy. He also directed one of his management staff to investigate whether there had been an increase in patient falls due to staffing patterns. Again, this written report was offered to Complainant.

The remainder of issues raised by Complainant on March 25 consisted of isolated incidents, rumors, or management issues. Honl was aware that a family member had erroneously given a medication by mouth and the resident had not been adversely affected. The lunch and breaks issue was one Honl appropriately left to the Director of Nursing to address.

Complainant presented no evidence at hearing demonstrating that Fitzsimons managers or administrators retaliated against her by targeting her for denial of breaks or lunches.

With regard to Mr. O'Neill's April 15, 2008 email to Manley, Manley immediately directed Honl to conduct a full investigation into the allegations. Honl directed his HR expert, Ms. SaBell, to conduct this investigation. The evidence demonstrates that Ms.

SaBell conducted a thorough investigation, interviewing eleven individuals and issuing a five-page, single spaced, detailed report. By the time the report was issued, Warner had been given a Corrective Action for his treatment of L.L. and had then been terminated for poor performance unrelated to L.L.

Significantly, Complainant refused to assist SaBell with her investigation, despite SaBell's repeated attempts to meet with her. Because Complainant did not testify, the reason for her lack of cooperation is unknown. No evidence in the record suggests that Respondent was motivated to retaliate against Complainant because of the April 15 disclosure.

Most importantly, Ms. Hamm, the new Director of Nursing at Fitzsimons as of May 2008, was unaware of Complainant's protected disclosures at the time she discovered Complainant's nursing errors and reported them to Honl. Hamm was motivated to impose disciplinary action against Complainant because of her observation of a pattern of substandard nursing care.

Hamm discovered Complainant's errors only after other staff had brought patient care issues to her attention in a manner unrelated to any particular nurse's conduct. For example, Schatz informed Hamm about E.U.'s enormous bruising on June 21; it was simply a matter of chance that Complainant had worked the prior shift. Nurses on the Constitution Unit informed Hamm of E.U.'s eight stasis ulcers after he had been transferred off of Complainant's unit; again, Hamm's response to this information was to examine the charting and assessment practices of all nurses who had cared for E.U., not just Complainant. What stood out for Hamm was Complainant's February 2008 Corrective Action and Education Plan indicating she had just been re-trained in assessments. It was appropriate for Hamm not to ignore the impression that this re-training had not improved Complainant's core nursing practices.

Lastly, Complainant's July 7 violation of the INR policy was brought to Hamm's attention by a nurse who worked the following morning. Hamm had no involvement in the initiation of this issue. In each instance, Hamm discovered Complainant's subpar nursing practice because of issues brought to her attention by other nurses.

As the new Director of Nursing at Fitzsimons, Hamm's response of closely examining the nursing practice of those under her authority was appropriate and necessary. Once she determined that Complainant's nursing practice showed a pattern of violating core nursing standards, she appropriately requested that Honl set up the predisciplinary meeting.

Complainant provided no mitigating information at the predisciplinary meeting, and many of her statements lacked credibility. For example, Complainant denied that the bruising on E.U. was new on June 21 after his fall, instead asserting that it had been reported to her on June 18. However, this explanation makes no sense for several reasons: no one, including Complainant, had charted bruising in that location on June 18;

the bruising was red and purple in color, indicating it was new; and, E.U. had fallen out of bed that morning. In addition, Complainant stated in her defense at the meeting that she relied on oral reports from nurses going off shift, instead of reading nurses notes in the medical record, in order to update herself on her patients' status.

These statements of Complainant at the predisciplinary meeting did nothing to instill confidence in Hamm's judgment of her core nursing practices. If anything, they demonstrated in Complainant a lack of self awareness or the ability to critique her own nursing practice.

The evidence demonstrated that Hamm was primarily responsible for the determination that it was in Fitzsimons' best interest that Complainant's employment be terminated. Honl supported the decision of his Director of Nursing. Therefore, it is concluded that Respondent was not motivated to terminate Complainant based on her protected disclosures. Respondent did not violate the whistleblower act.

Assuming for the sake of argument that Complainant had met her burden of proving that Complainant's disclosures were a substantial or motivating factor in terminating Complainant's employment, Respondent has demonstrated that it would have made the decision even in the absence of those disclosures. *Taylor, supra.*

Each one of the mistakes Complainant made would not, by itself, serve as a basis for termination. However, the pattern of conduct from February through July was sufficiently serious to Hamm to warrant termination. Charting the administration of medications is a daily part of a nurse's routine: when a medication is given it is contemporaneously charted in the MAR. To neglect to chart a 200mg dose of Lasix presents a real danger to the patient with heart trauma. On the acute care unit, after a patient falls and no one has seen the fall, close monitoring and charting of those assessments is the clear duty of the nurse in charge of that patient. To neglect that patient for a ten-hour period is a fundamental breach of the duty of care. The INR policy of obtaining an extra blood draw after a 3.5 reading is a routine policy. To neglect the extra blood draw is a violation not only of the policy but of the duty of care to the patient who is highly susceptible to external or internal bleeding. Hamm and Honl did not feel it was appropriate to have Complainant continue to care for the Fitzsimons residents.

D. The discipline imposed was within the range of reasonable alternatives.

State Personnel Board Rule 6-2 requires that certified employees are to receive corrective action before disciplinary action unless the act is so flagrant or serious that immediate discipline is proper. Complainant received a corrective action for failing to implement at stat order on a very ill patient, in February 2008. Therefore, Respondent was justified in imposing progressive discipline in the event additional nursing practice problems ensued.

In February 2008, Complainant was placed on an Education Plan, under which she

received significant re-training in assessments and other core nursing functions. She also received INR policy and wound care training during in early 2008. Nonetheless, she violated core assessment, wound care, and charting standards of practice during the month of June. In addition, she violated the INR policy in July.

Complainant's pattern of performance errors in June and July of 2008 was sufficiently serious that it was within the range of reasonable alternatives to terminate her employment. While a lesser disciplinary action would also have been appropriate, it was within the Director of Nursing and the Administrator's discretion to decide on termination.

CONCLUSIONS OF LAW

1. Complainant committed the acts for which she was disciplined.

2. Respondent's disciplinary action was not arbitrary, capricious, or contrary to rule or law.

3. The discipline imposed was within the range of reasonable alternatives.

ORDER

Respondent's action is **affirmed**. Complainant's appeal is dismissed with prejudice.

Dated this 2nd day of April, 2009.

[redacted]

Mary S. McClatchey
Administrative Law Judge
633 – 17th Street, Suite 1320
Denver, CO 80202
303-866-3300

NOTICE OF APPEAL RIGHTS

EACH PARTY HAS THE FOLLOWING RIGHTS

1. To abide by the decision of the Administrative Law Judge ("ALJ").
2. To appeal the decision of the ALJ to the State Personnel Board ("Board"). To appeal the decision of the ALJ, a party must file a designation of record with the Board within twenty (20) calendar days of the date the decision of the ALJ is mailed to the parties. Section 24-4-105(15), C.R.S. Additionally, a written notice of appeal must be filed with the State Personnel Board within thirty (30) calendar days after the decision of the ALJ is mailed to the parties. Section 24-4-105(14)(a)(II) and 24-50-125.4(4) C.R.S. and Board Rule 8-67, 4 CCR 801. The appeal must describe, in detail, the basis for the appeal, the specific findings of fact and/or conclusions of law that the party alleges to be improper and the remedy being sought. Board Rule 8-70, 4 CCR 801. Both the designation of record and the notice of appeal must be received by the Board no later than the applicable twenty (20) or thirty (30) calendar day deadline referred to above. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Colo. App. 1990); Sections 24-4-105(14) and (15), C.R.S.); Board Rule 8-68, 4 CCR 801.
3. The parties are hereby advised that this constitutes the Board's motion, pursuant to Section 24-4-105(14)(a)(II), C.R.S., to review this Initial Decision regardless of whether the parties file exceptions.

RECORD ON APPEAL

The cost to prepare the record on appeal in this case is $50.00. This amount does not include the cost of a transcript, which must be paid by the party that files the appeal. That party may pay the preparation fee either by check or, in the case of a governmental entity, documentary proof that actual payment already has been made to the Board through COFRS. A party that is financially unable to pay the preparation fee may file a motion for waiver of the fee. That motion must include information showing that the party is indigent or explaining why the party is financially unable to pay the fee.

Any party wishing to have a transcript made part of the record is responsible for having the transcript prepared. Board Rule 8-69, 4 CCR 801. To be certified as part of the record, an original transcript must be prepared by a disinterested, recognized transcriber and filed with the Board within 59 days of the date of the designation of record. For additional information contact the State Personnel Board office at (303) 866-3300.

BRIEFS ON APPEAL

When the Certificate of Record of Hearing Proceedings is mailed to the parties, signifying the Board's certification of the record, the parties will be notified of the briefing schedule and the due dates of the opening, answer and reply briefs and other details regarding the filing of the briefs, as set forth in Board Rule 8-72, 4 CCR 801.

ORAL ARGUMENT ON APPEAL

A request for oral argument must be filed with the Board on or before the date a party's brief is due. Board Rule 8-75, 4 CCR 801. Requests for oral argument are seldom granted.

PETITION FOR RECONSIDERATION

A petition for reconsideration of the decision of the ALJ must be filed within 5 calendar days after receipt of the decision of the ALJ. The petition for reconsideration must allege an oversight or misapprehension by the ALJ. The filing of a petition for reconsideration does not extend the thirty-calendar day deadline, described above, for filing a notice of appeal of the ALJ's decision. Board Rule 8-65, 4 CCR 801.

CERTIFICATE OF SERVICE

This is to certify that on the 10th day of April, 2009, I placed true copies of the foregoing **INITIAL DECISION OF ADMINISTRATIVE LAW JUDGE and NOTICE OF APPEAL RIGHTS** in the United States mail, postage prepaid, addressed as follows:

Judy Wilday-O'Neill
[redacted]

and in the interagency mail, to:

Michael Scott
[redacted]

[redacted]
Andrea C. Woods

(rev'd. 5/07)