COMMONWEALTH OF PENNSYLVANIA

Theresa R. Zajac	:	State Civil Service Commission
	:	
v.	:	
	:	
Department of Human Services, Danville State Hospital	:	Appeal No. 29734

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ADJUDICATION

This is an appeal by Theresa R. Zajac challenging her five-day suspension from regular Registered Nurse employment with the Danville State Hospital, Department of Human Services. A hearing was held March 15-16, 2018, and May 3, 2018 at the Danville State Hospital in Danville, Pennsylvania before Commissioner Gregory M. Lane.

The Commissioners have reviewed the Notes of Testimony and exhibits introduced at the hearing, as well as the Briefs submitted by the parties. The issues before the Commission are: 1) whether the appointing authority had cause sufficient, under the Civil Service Act, to suspend appellant from her position; and 2) whether the decision to suspend appellant was affected by discrimination violative of the Civil Service Act's prohibition of discrimination.

FINDINGS OF FACT

1. By letter dated August 18, 2017,[1] appellant was advised that a suspension pending investigation, initiated July 20, 2017 and extending for a period of twenty-two full work days, had concluded; the letter informed appellant that the investigation had led the appointing authority to impose a five-day suspension, effective July 20-28, 2017. Comm. Ex. A.

2. The August 18 letter directed appellant to return to her regular status Registered Nurse (hereinafter "RN") employment on August 21, 2017; the letter informed appellant that she would "be made whole for the remaining days, both partial and full, of the suspension pending investigation." Comm. Ex. A.

3. The August 18 letter included the following statements:

   The reason for this suspension is:

   1. "Falsification of an Official Record or Document" as

[1] The appointing authority later, by letter dated October 27, 2017, issued a "Corrected" version of the August 18, 2017 letter. Comm. Ex. A; AA Ex. 6. The only substantive difference between the two letters is that the earlier version included a reference to a 2008 reprimand; the later version omits that statement. N.T. pp. 494-499. Both versions have been incorporated as part of the Commission Exhibit. At the hearing, appellant accepted the appointing authority's claim that the prior discipline was a typographic error and was not a factor in the suspension decision. N.T. pp. 815-817.

> defined in DHS Human Resource Policy 7174.
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> * * *
>
> 2. "Negligent Individual Abuse" as defined in DHS Human Resource Policy 7178.
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> * * *
>
> 3. "Failure to Follow General Instructions or Procedures" as defined in DHS Human Resource Policy 7174.

Comm. Ex. A.

4. The appeal was properly raised before this Commission and was heard under Sections 951(a) and 951(b) of the Civil Service Act, as amended. Comm. Exs. B-E.

5. Appellant has been a nurse since 2000. N.T. p. 546. Appellant was initially employed in the Registered Nurse classification for 3.5 years, beginning in 2002, at the appointing authority's Harrisburg State Hospital. N.T. p. 550.

6. Appellant was employed as a Registered Nurse at the Danville State Hospital (hereinafter "the Hospital") for approximately 12.5 years; N.T. pp.

545, 546, 550. Appellant moved to the Hospital due to the August 2005 closure of the Harrisburg State Hospital. N.T. p. 550.

7. The Hospital is a residential facility for the treatment of psychiatric patients.[2] N.T. pp. 42, 71. At the Hospital, appellant was assigned to Unit 210 for approximately eight years. N.T. p. 550. She was assigned to Unit 310 for one year, beginning in 2013; in February 2014, appellant moved to Unit 311. N.T. p. 551.

8. Appellant is aphasic; her life-long condition manifests as a speech impediment affecting her ability to speak in a readily understandable way. N.T. p. 556.

9. During 2017, appellant was assigned to the night shift[3]—extending from 11:00 p.m. to 7:00 a.m. (2300 to 0700). N.T. p. 564. Beginning May 2017, she was reassigned as one of two nurses on Unit 310 on the third shift. N.T. pp. 606-607, 624.

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[2] Throughout the record, the terms "consumer," "resident," and "patient" have been used interchangeably. N.T. p. 42.

[3] The Hospital, as a 24-hour facility, operates three daily shifts—dayshift (a.k.a. first shift), afternoon shift (second shift) and nightshift. The night shift is also referred to as the overnight or third or evening shift. N.T. pp. 104, 191, 256, 272, 783-784.

10. The duties of a registered nurse center upon the care of the Hospital's patients. On the night shift, duties include auditing charts, following up on doctors' orders, administering medications and performing treatments. N.T. pp. 256, 622-625. Registered Nurses are expected to be familiar with the Hospital's policies and procedures. N.T. pp. 42, 264, 306.

11. Throughout 2017, appellant had been apprised of performance issues through the following:

    a. Annual EPR issued January 30;
    b. Work Plan for February 11 to February 25, issued February 11;
    c. Interim EPR issued February 25;
    d. Work Plan for February 25 to March 11, dated March 21;
    e. Interim EPR issued March 23;
    f. Work Plan Review for March 11 to March 26 dated April 11;
    g. Work Plan for March 26 to April 11, dated April 15;
    h. Interim EPR issued April 18;
    i. Work Plan Review for March 26 to April 22, dated May 2;
    j. Work Plan for April 23 to May 6 dated May 2;
    k. Interim EPR issued May 25;

l. Interim EPR issued June 26.

N.T. pp. 386-390; AA Ex. 5.

12. During appellant's tenure, M.S. was a patient housed on Unit 310. N.T. p. 629. In June 2017, following a hip fracture, M.S. was prescribed morphine; the prescription was designated "PRN"—to be given only when M.S. needed and wanted. N.T. pp. 629-630, 673, 676; AA Ex. 1, Attachment D-28.

13. For a period extending from July 3 to July 17, 2017, M.S.' morphine prescription was changed from PRN to a doctor's order requiring that it be administered every four hours. N.T. pp. 630, 680; AA Ex. 1 Attachment D-18. Under the noted regimen, two administrations—2400 (midnight) and 0400 (4:00 a.m.)—would occur during the night shift. N.T. p. 630.

14. Appellant was on duty on Unit 310 on the night shift of July 11-12, 2017; appellant was the only RN on duty that shift. N.T. pp. 633, 650. M.S. was the only patient on Unit 310 receiving morphine. N.T.

pp. 64, 632-633. M.S. was one of two patients on the unit scheduled to receive medication during that night shift. N.T. pp. 786-787.

15. The Hospital allows a two-hour window—extending from one hour before the designated time to one hour after—during which medications may be administered to patients. N.T. pp. 55-56, 134, 282, 634-635; AA Ex. 1, Attachment D-35, p. 2 of 5; Ap. Ex. 20, p. 2 of 5. Only RNs are permitted to administer medications.

16. During the night shift on July 11-12, 2017, appellant, during the two-hour period extending from 11:00 p.m. to 1:00 a.m. did not obtain or otherwise prepare to administer morphine as scheduled for M.S. at midnight. N.T. pp. 57, 73, 636-637; AA Ex. 2A.

17. Appellant placed an "R" on M.S.' Medication Administration Record (hereinafter "MAR") thereby documenting that M.S. had refused the scheduled midnight July 11 dose. N.T. pp. 83-84, 689-691; AA Ex. 1, Attachment D-18-c.

18. On at least one subsequent occasion, appellant made a statement to the appointing authority implying

that she had prepared and proffered the midnight July 11 dose. On a notarized statement dated August 2, 2017, prepared by appellant she stated that she:

> [t]ried giving SL (sublingual)" narcotic to patient. She refused. Was able to save the contents of the tiny syringe, so returned it to the Narc drawer.

AA Ex. 10, p. 1.

19. A doctor's order is required to permit a patient to either self-perform a glucose test or to self-administer insulin. N.T. pp. 80-81. During the July 11-12 night shift, appellant, on the morning of July 12, allowed three patients to self-perform their glucose tests and to self-administer their insulin: a) one of the three had an order to self-perform her glucose test; b) one had an order to self-administer her insulin; and c) the third had neither. N.T. pp. 329-330, 657-659, 754-755.

20. On July 17, 2017, at approximately 0630, appellant left consumer L.H. unattended and did not supervise her performing a glucometer check and did not supervise her self-administering insulin. Appellant left the medication room for approximately three minutes and ten seconds while the consumer self-

administered medication. Appellant did not have the MAR in the medication room. The consumer did not have an order to perform glucometer checks or administer insulin under a nurse's supervision. N.T. pp. 64-69; Commission Ex. I,[4] Parties' Stipulation # 1.

21. A pre-disciplinary conference (hereinafter "PDC") was conducted with appellant on August 14, 2017. N.T. pp. 321-322, 326, 335; AA Ex. 4; Ap. Ex. 19.

DISCUSSION

Appellant challenges a five-day suspension from regular Registered Nurse employment with the appointing authority. She has brought her challenge under Sections 951(a) and 951(b) of the Civil Service Act. Comm. Ex. B. In an appeal brought under Section 951(a), the burden of proof requires that the appointing authority present evidence at hearing to establish that the adverse personnel action was imposed for cause sufficient under the Civil Service Act. *Benjamin v. Commonwealth, State Civil Service Commission*, 17 Pa. Commw. 427, 431, 332 A.2d 585, 587 (1975); 71 P.S. § 741.951(a); 4 Pa. Code § 105.15. Under Section 803 of the Act, a regular status employee may only be suspended for "good" cause. *Salvati v. Berks County Board of Assistance, Department of Public Welfare*, 81 Pa.

[4] Although the noted Stipulation was introduced in writing and discussed at the hearing, the written statement, inadvertently, was not admitted as part of the record. N.T. pp. 22-23, 64-69. To correct the record, the document is hereby placed onto the record, presumably without objection by either party. The Stipulation will be designated as Commission Exhibit I.

Commw. 629, 631-632, 474 A.2d 399, 400-401 (1984); 71 P.S. § 741.803; 4 Pa. Code § 101.21. Accordingly, the matter before the Commission is to determine whether the suspension was for good cause.

Relative to the claim under Section 951(b), the burden has been assigned to appellant to present evidence establishing that discrimination violative of Section 905.1 of the Act was a factor in the suspension decision. 71 P.S. §§ 741.803, 741.951(a); 4 Pa. Code §§ 105.15, 105.16. Actions brought under Section 951(b) can be addressed as either of two general types of discrimination—"traditional discrimination" which relates to claims of intentional discrimination based on labor union affiliation, race, gender, national origin or other non-merit factors, or "technical discrimination" which involves a violation of procedures required pursuant to the Act or related Rules. *Price v. Luzerne/Wyoming Counties Area Agency on Aging*, 672 A.2d 409, 411 n. 4 (Pa. Commw. 1996), citing *Pronko v. Department of Revenue*, 114 Pa. Commw. 428, 539 A.2d 462 (1988). The Appeal Request submitted to initiate the current action (Comm. Ex. B) states allegations of age-based discrimination,[5] disability-based discrimination and retaliation.

In presenting its case, an appointing authority is expected to present evidence sufficient to prove the charges stated, in the written notice provided the appellant, as bases for its action. *Long v. Commonwealth, Pennsylvania Liquor*

[5] Appellant's allegation of age-based discrimination was withdrawn at the hearing. N.T. pp. 18-19.

Control Board, 112 Pa. Commw. 572, 535 A.2d 1233 (1988). The written notice of suspension received by the current appellant contained the following statement:

> The reason for this suspension is:
>
> 1. "**Falsification of An Official Record or Document" as defined in DHS Human Resource Policy 7174**
>
>   On July 11, 2017 at 2400 you did not administer Morphine Oral Solution to a consumer for who it was ordered. You documented the consumer refused the medication; however, it was never taken to her room to be offered which is resultantly a medication omission.
>
>   A completed investigation revealed this medication omission which is supported by video footage.
>
> 2. "**Negligent Individual Abuse" as defined in DHS Human Resource Policy 7178**
>
>   On July 11, 2017 at 2400 you did not administer Morphine Oral Solution to a consumer for who it was ordered.
>
>   A completed investigation revealed this medication omission which is supported by video footage.
>
> 3. "**Failure to Follow General Instructions and Procedures" as defined in DHS Human Resource Policy 7174**
>
>   A. On July 17, 2017 at approximately 0630 you left consumer L.H. unattended and did not supervise her performing a glucometer check and you did not supervise her self-administering insulin. You left the medication room for approximately 3

minutes and 10 seconds while the consumer self-administered medication. You did not have the Medication Administration Record (MAR) in the medication room. The consumer did not have an order to perform glucometer checks or administer insulin under a nurses' supervision.

B. On July 12, 2017 at 0615 you did not follow proper documentation technique in your progress note for M.S. In small print you wrote between the lines of your progress notes, "Refused 2400 Morphine dose but took 0400 dose of Morphine."

C. In addition, on July 12, 2017 between approximately 0515-0630, you administered medications to a consumer without referencing the MAR. That same morning you allowed three consumers to perform glucometer checks and administer insulin without referencing the MAR. You did not supervise these consumers when they administered their insulin, and they did not have an order to self-administer their own insulin. Also, you did not change gloves between any of these consumer contacts.

D. On July 15, 2017, at 2344 you entered C.Y.'s room to administer oral morphine solution but where [sic] prevented by staff members intervening and telling you it was the wrong consumer room.

A completed investigation revealed your "Failure to Follow Procedures"

> for all incidents described above and is supported by video footage.
>
> **This is contrary to the following DHS Policy/Procedures:**
>
> - **AD101.306 Administration of Insulin**
> - **AE101.465 Blood Glucose Monitoring System, True Metrex Pro**
> - **AD101.301 Administration of Medication**
> - **100.105 Controlled Substances**
> - **IA 109.229 Hand Hygiene, Health Care Setting**
> - **AC101.207 Documentation, Nursing**

Comm. Ex. A, pp. 1-2.

In support of its action, the appointing authority presented documents and introduced testimony through eight witnesses—Katherine Coleman, Stacie Buck, Belinda Gordner, Eunice Smith, Jill Temple, Diane Dalberto, Thomas Burk, and Shelly Swank. Appellant was the sole witness in opposition.

At all times relevant to the current appeal, Katherine Coleman was employed as a Nurse Manager at the appointing authority's Danville State Hospital. N.T. p. 41. In July 2017, Coleman was assigned to conduct an abuse investigation in which appellant was the target. N.T. p. 43. She prepared a written report of the investigation. N.T. pp. 46-47; AA Ex. 1. Coleman testified as follows regarding the documentation provided by appellant:

> I noted a discrepancy in times and dates on the MAR—which the MAR is a medication administration record, if I can use that term, and the controlled substance record. . . . some of the nurses inadvertently documented on the medication record for the 2400-hour dose, which is midnight, a day ahead of time. But the documentation on the controlled [substance] record was correct.

N.T. p. 48. Coleman testified that the differences led her to review video recordings and other information to verify what had happened. N.T. p. 48.

Coleman's examination of the video required that she ascertain the locations of patient rooms, review policies and procedures, interview witnesses and take witness statements. N.T. p. 51. She testified that she reviewed video recorded from cameras sited in various locations, including patient areas and the medication room. N.T. p. 54. Coleman stated, "What I was looking for here was to see if morphine was administered to patient M.S. [] for 2400." N.T. p. 55. She testified that she did not see appellant get morphine for patient M.S. on July 11-12, 2017 during a period extending from one hour before to one hour after her scheduled midnight dose. N.T. pp. 55-58; AA Ex. 2a.

Coleman, while watching video from July 15, 2017 (AA Ex. 2b) described that she saw appellant leaving the nurse's station with a medication record and, carrying in her right hand a syringe of oral morphine solution. She testified that the video depicted appellant going to patient C.Y.'s room "and [appellant] walks in the room, takes the lid off, comes out. Looks to see the name on the door, is what I believe she's looking at. Talking to the person inside in the special level should say it's a nurse. Then see, the morphine is still in her hand. And walks down the hall." N.T. p. 61.

When asked to explain why appellant's actions cause concern, Coleman testified:

> Well, not finding the right room is a concern. Because you have to find the right patient in the right room. And they could get the wrong patient, get the wrong medicine, could be lethal.
>
> Number two, the actual medication record wasn't even taken down to that other room where the patient was to receive it. There's a way that you identify patients. In order to give medicine, you have to identify them correctly. And if they're not identified correctly, how do you know who you're giving it to.

N.T. p. 70. Coleman additionally testified regarding the appointing authority's documentation policies and noted several violations by appellant; Coleman also described another video recording and the infractions she saw during patients' administering their own glucose checks and insulin. N.T. pp. 78-82.

Stacie Buck, a Psychiatric Aide at the Hospital, indicated that she worked overnight on July 11-12, 2017. N.T. p. 224. She was assigned to one-to-one observation of consumer M.S. from 12:00 midnight to 1:00 a.m. and from 4:00 a.m. to 5:00 a.m. N.T. p. 224. Buck testified that appellant was the nurse assigned to give medications that night. N.T. p. 225. Buck acknowledged that she provided a written statement, dated July 18, 2017, on which she stated, *inter alia*:

> I did not see [M.S.] receive any meds. I did not see [M.S.] receive any meds while on a 1-1 when [appellant] was working.

N.T. pp. 227-228; Ap. Ex. 11. On redirect-examination, Buck indicated that she had seen appellant confused as to which patients were in which rooms "numerous times." N.T. p. 241.

Belinda Gordner, a Registered Nurse normally assigned to the Hospital's nightshift, performed overtime work as a Psychiatric Aide on the July 15, 2017 nightshift. N.T. p. 257. In response to a question asking what she observed appellant doing that night at 2344, Gordner testified:

> What she did was I was sitting with C.Y. and I had happened to look at my watch because I wanted to make sure that the observation sheet was correct, as far as documentation like two-to-one and the one-to-one. While I was sitting with C.Y.
>
> * * *
>
> [Appellant] had come in to give [C.Y.] her medication.
>
> * * *
>
> [Appellant] came with a syringe. And she was going to medicate C.Y.

N.T. pp. 258-261. Gordner indicated that, as a Registered Nurse, she recognized the medication as morphine; morphine was not prescribed for C.Y. N.T. p. 261. Gordner testified that she had previously seen appellant confuse consumers. N.T. p. 262. Gordner indicated that appellant's failure to identify the patient was not consistent with the Hospital's practices. N.T. p. 264. Gordner reported the incident. N.T. p. 264.

Gordner also testified with regard to the evening shift starting at 2300 on July 11. N.T. p. 271. She identified her signature and that of appellant on a "Narcotic and Controlled Drug Inventory" form, noting that her signature appeared

on the lower of two lines labeled July 11 night and that appellant's signature appeared on the top of two lines labeled July 12 day. N.T. p. 273; AA Ex. 1, Attachment D-39. According to Gordner, the signatures indicated that she was finishing her shift at 2300 and appellant was starting hers at that time. N.T. p. 273. Gordner testified that she does remember seeing appellant leaving the medication room with morphine for patient M.S. N.T. p. 283. On cross-examination, Gordner noted that she had, on a witness statement dated July 19, 2017, indicated that she [Gordner] had dosed M.S. with morphine on that date at 2400 and at 0400 on July 12. N.T. pp. 285-286; Ap. Ex. 4.

Eunice Smith, a Registered Nurse employed at the Hospital, indicated that she worked on Unit 310 on the night of July 15-16, 2017. N.T. p. 302. When asked what she observed appellant doing that night at 2344 involving patient C.Y., Smith testified:

> I was sitting down the hallway on a one-to-one in the doorway because of the nature of that consumer. And I saw [appellant] come out of the nursing office with a syringe, which I identified as a morphine that we've been giving to [M.S.]. And I saw her come down the hallway and enter the first room on the right, which was [C.Y.]'s room. And I knew that [C.Y.] had a one-to-one who was another RN that was in there. And I was alarmed a little bit .
>
> * * *
>
> I saw she went into that room. And I waited for a few moments. I heard the person that was in there. I heard her voice elevated. But I didn't hear what was said. I just knew that she responded. And then I saw [appellant] come out of the room.

N.T. pp. 302-304. Smith testified that she reported the incident. N.T. p. 306. Smith indicated that appellant's entry into the room of a patient other that the one due the

medication with a syringe ready for administration was not consistent with the Hospital's practices. N.T. p. 307.

Jill Temple, a Nurse Manager at the Hospital, testified that, after the investigation was completed, she conducted a pre-disciplinary conference for appellant; she explained that a PDC gives an employee a chance to "answer the allegations and explain their actions." N.T. pp. 321-322. According to Temple, three charges were addressed during the PDC:

> [Appointing authority] Policy 7178, negligent individual abuse. [appointing authority Policy] 7174, falsification of official record. And [appointing authority] Policy 7174, failure to follow general instructions or procedures.

N.T. p. 322.

Temple, when asked what responses were given by appellant regarding the noted allegations, testified:

> Specifically to the falsification of an official record or document, [appellant] said that she, [M.S.] had refused the med. But I made her aware there was video footage showing that she had not entered [M.S.]'s room from the hours of 11:00 p.m., 2300 to 0100. And that the nursing staff members sitting with her said she had not entered the room. So she couldn't answer when she had asked her to receive the med, the morphine.
>
> Under the negligent individual abuse charge, it should be noted that [appellant] said that she felt no harm or neglect was done to the patient. But it should be noted that morphine is a strong narcotic med that was ordered for the patient by the doctor, status post hip surgery to control her pain.
>
> Under the failure to follow general instructions or procedures, there was four different sections to that.

Things that had not been followed according to policy. [Appellant] did admit that it was wrong to leave [L.H.]. unattended to administer her insulin that morning. She said then later that she only left her alone for a few minutes. But I pointed out that she had left her alone for three minutes and ten seconds per the video footage.

Under the B, for the failure to follow, [appellant] also admitted that she added in small print to [M.S.]'s medical record the documentation at a later date. And she actually told me during the PDC that she knew that that wasn't right. So that is why she went back two days later and added a documentation in on July 14th. Which I didn't have with me at that time. I didn't realize she had done that, but I did check. And it was there that she indicated that she did this. During the PDC, she told me she did this because she knew she had added to a previous documentation. And she knew she shouldn't have inserted the information.

* * *

And under the failure to follow general instructions or procedures on the part of C there, she relayed that at the beginning of the night, she checks all the doctor's orders as she comes in. And she writes down things that she needs to administer in the morning, glucometers and meds. And she writes them on a piece of paper. And I reviewed that that is not how, you know, policy and procedure is to do. That you need to have an MAR, a medication administration record with you. That that's not an acceptable practice. And she said, you know, that by now, I know who gets what.

She also insisted that [C.D.] and [V.W.] both had orders to do their own glucometers. But I did check, because I wanted to verify because she thought that that was so. And I did check. And I did add this to my note that they did not have order to perform the checks at that time on July 12th. [L.H.] did. But [V.W.] was – they were to order under basically observation. And that did not happen. That [appellant] did not observe them during the process.

> And the medication administration record was not in the room to refer to.
>
> I made her aware that she didn't change gloves between consumer contact. And that she actually, I was on the video, that it showed she changed – she got a garbage bag for another consumer with a soiled attend. And still did not change gloves between the consumers. And [appellant] admitted that she took shortcuts and made mistakes that night.
>
> And then under part D., the last failure to follow charge. When she was confronted about how she would identify a patient, that she went to [C.Y.]'s room and was going to give the morphine sulfate, she said she, you know, had identified the patient by looking at her face. But the person had to tell her that, you know, she was with the wrong consumer. She said she would have picked that up first. But couldn't say how she would have identified if they hadn't told them.
>
> I reviewed the Nurse Practice Act, how as nurses, we're responsible to administer medication safely, and document accurately, and just ensure general consumer safety. And during that time, [appellant] said that she was questioning what harm she had done by not giving [M.S.] the 2400 pain med, which I was, you know, necessitated by the doctor's order. She said she never takes it for her at midnight. And that it's easier to give it to her at 4:00 in the morning because she's sleeping. And then just slips it under her tongue while she's asleep. And I made her aware that's not practice that's acceptable because a patient needs to know they're receiving a medication.

N.T. pp. 326-332. Temple testified that she did not find appellant's responses acceptable, noting appellant had admitted wrongdoing and failure to follow policies. N.T. p. 332.

Diana Dalberto, the Hospital's Chief Nurse Executive, when asked how she determined to impose a five-day suspension, responded:

> What we looked at was that there was an EPR or an evaluation that was done recently. And we looked at that, along with how we tried to help with that EPR process with interim EPRs and so forth. And we looked at the infractions that were held, the charges that were there on the discipline or the PDC. And that's how we determined due to the significance of it, and the prior history with trying to work with the issues, that that was warranted. Five-days was warranted.

N.T. p. 365.

Dalberto indicated that prior to July 2017, she had been aware of issues regarding appellant's administration of medications. N.T. p. 386. She noted that appellant's January 30, 2017 annual performance evaluation and subsequent Work Plans and Interim EPRs addressed issues of medication administration and counting controlled substances. N.T. pp. 386-389; AA Ex. 5. Dalberto also testified regarding additional performance issues that were addressed, including appellant's relationship with coworkers, stating:

> as a charge nurse, we look to the charge nurses to be the role model for the units. And they set the tone for the rest of the workforce because they do direct the workforce. And so that was of concern because when things would get --- if things would get busy on the unit, or there was a situation occurring on the unit, again, looking at the timeliness, if you get flustered, it's you know, you have to stay calm. And because, again you're directing the workforce.
>
> And there were situations where noted that there would be an altercation in front of others between a co-worker, even from shift to shift, that there was an altercation. And that was in the presence of other staff members.

> And so we look to our charge nurses to be that role model. And to keep their cool in a stressful situation. And so when we're unprofessional to our co-workers and our peers, other staff feed into that. And that's unprofessional in our role. We need to keep our cool.

N.T. pp. 390-391. On cross-examination, Dalberto acknowledged that she did not review the surveillance video and witness statements gathered during the investigation or conduct her own interviews. N.T. pp. 392-394.

Thomas Burk, the Hospital's Chief Operating Officer, was a member of the panel which determined that appellant's infractions merited a five-day suspension. N.T. p. 444. Burk noted that appellant's actions constituted poor patient care and "could have jeopardized the integrity of our care to our patients . . ." N.T. pp. 445-446. The appointing authority could have been liable in a lawsuit. N.T. p. 446. When asked to describe the process by which it reached a conclusion on appropriate discipline, Burk testified:

> After an investigation was conducted, we reviewed the investigation as a panel. And the panel included CEO, myself and the nursing director. After the review of that, we then looked at the circumstances. And that the circumstances [] warranted the five-day because of the severity of the nature of the infractions. And by themselves, warranted five-day suspension with final [warning].
>
> We probably could have looked at even a termination right away. But due to the length of service of the employee, we deemed that this was more appropriate.

N.T. pp. 446-447.

Shelly Swank, the Hospital's Labor Relations Coordinator, prepared the written notices advising appellant of: 1) her initial suspension pending investigation; 2) the conversion of that initial suspension to one of five days; and 3) a correction to the notice of five-day suspension. N.T. pp. 493-494, 498. At the hearing, Swank acknowledged that the first notice of five-day suspension she drafted, improperly referenced a 2008 discipline which should have been purged from appellant's file.[6] N.T. pp. 494-495. Swank testified that she was first advised of this error by her immediate supervisor; appellant later contacted her to similarly note the error. N.T. pp. 495-496. Swank indicated that she was not involved in the determination of discipline and that she never apprised the individuals who made that determination about the 2008 discipline. N.T. p. 498.

Appellant testified that although she had worked under the supervision of Holly Long while on second shift, she "started seeing change" when they were both working third shift. N.T. p. 555. Appellant described Long's attitude toward her as "dismissive." N.T. p. 555. Appellant testified that Long began working third shift in January 2017. N.T. p. 565. According to appellant, "the attitude by [Lynn] O'Shea, my supervisor, she changed toward me. She changed her attitude toward me. She was avoiding me. And I didn't see her doing her supervisory rounds." N.T. p. 566.

Appellant noted that in the years prior to January 2017, she had been "at least rated satisfactory to commendable" on her annual EPRs. N.T. pp. 568-571; Ap. Exs. 22-24. Appellant testified that her 2016 annual evaluation was not received

[6] At the hearing, appellant specifically noted that she accepts that the appointing authority did not consider the 2008 discipline when making the decision to impose the current disciplinary action. N.T. pp. 815-817.

until February 2017—rather than January when she received prior EPRs; appellant noted that she was ranked "needs improvement" on four of seven ranked categories and "overall." N.T. pp. 572, 573-574; Ap Ex. 25. She explained, that:

> The year 2016 was, I think, the most stressful year I had on third shift. Because I worked on Unit 311 and most of the time, I was by myself as a licensed nurse.

N.T. p. 574. Appellant particularly noted the "needs improvement" rating on the "interpersonal relations/affirmative action" job factor which included a comment asserting that she "verbally project[s] frustration in [her] interactions with others." N.T. p. 575; Ap. Ex. 25, p. 12. A plan correction included with the comment directed that appellant learn to "speak slowly and calmly." N.T. p. 575; Ap. Ex. 25, p. 12.

Appellant corroborated earlier testimony by acknowledging that she was placed on a work plan as a result of the EPR. N.T. p. 577. She however noted that work plans—dated February 25, 2017 (Ap. Ex. 26), March 11 (Ap. Ex. 27), March 21 (Ap. Ex. 28), April 11 (Ap. Ex. 29) and April 15 (Ap. Ex. 30) all included directives that she "refrain from using a loud tone of voice while on duty" and "keep others informed in a respectful manner." N.T. pp. 578-581. Appellant noted that the March 11 and later work plans were prepared by an individual (Deb Zechman) who became her immediate supervisor sometime in February. N.T. pp. 581-583.

Appellant testified that the first time she went to deliver papers to Zechman,

> I just simply laid the papers down on the table. And I said hi [Zechman]. And all of the sudden she said so did you take control of your stuttering, and are you managing your speech.
>
> * * *

> I didn't know her. She was new. And I wanted to greet her. And I was very taken by surprise. I just walked out from the nursing office. And I felt a sudden disbelief and my heart was pounding. I mean, I couldn't even like be introduced to her. And just, it was something that I didn't even want to think about. But there was then continuations.

N.T. pp. 584, 589. Among the claimed "continuations," appellant testified that when she was reassigned to Unit 310, "[Zechman] told me that I was going to Unit 310 to learn to be more assertive and to talk more calmly." N.T. p. 590.

Appellant additionally noted an incident which occurred while learning to use a new computerized report, when appellant addressed "something I was curious about and I brought it up. And when I did, [Zechman] told me stop stuttering. There were other people around." N.T. p. 600. Appellant testified:

> That's why I actually think that on 310, that the staff up there didn't like me. That they seemed to have a different attitude toward me. And I kind of think it stemmed from the supervisor and even Holly Long.

N.T. pp. 600-601.

When asked to describe any incidents with Holly Long, appellant testified:

> my very first day as --- on permanent assignment on 310, I was working in the medication room on a project, that only I was working to accomplish that had to be done. My co-worker stayed out in the nurse's station. And [Long], along with [Zechman], and also my co-worker came in at the same time. They --- [Long] started asking questions. And being that I was the one working on it, I thought it

> was appropriate for me to answer. As soon as I started answering [Long], she said hush. Shut up. I'm not talking to you. We know how you talk.

N.T. pp. 601-602. An additional incident noted by appellant involved Long telling appellant "you and your talk, how do you expect anybody to understand you?" N.T. p. 602. Appellant further testified: "Nobody asked me is there --- like your speech seems to be off. Do you want to talk about it? But they treat me --- they started treating me all of a sudden like strange, different." N.T. p. 603.

Appellant then noted an incident during which Long said "so you can pull a wabbit out of a hat;" copying appellant's speech impediment. N.T. pp. 603-604. An additional incident involved Long,

> criticizing me as my speech is very disrespectful and too loud when . . . I'm speaking to staff.
>
> And then she went on and said that you need to learn how to lower your voice and watch how you talk and stutter.

N.T. p. 605. Appellant testified that the incidents made her feel "very inferior and humiliated." N.T. p. 606.

Appellant testified that, prior to her movement to Unit 310, three nurses were assigned there; immediately after her placement, the complement was reduced to her and one other nurse. N.T. pp. 606-607. Appellant also noted that, at the time of her movement to Unit 310, there were no SLO patients[7] on the unit; soon after her

[7] Appellant explained that the acronym "SLO" refers to a special level of observation assigned for a patient by order of a physician (or psychiatrist). N.T. pp. 607-608.

arrival, there were three. N.T. p. 609. According to appellant these changes caused staffing issues; she testified:

> It was difficult for the nursing office to call and get extra people in there to accommodate for the SLOs. And then, I think as far as I know, the Unit 310, they don't normally have a lot of SLOs. And there was a very -- there was -- there wasn't quite enough staff people. And I think it caused some extra stress among the staff.

N.T. p. 609. Two attempts by appellant to obtain additional help, resulted in one unanswered telephone call and Zechman's statement that she could not provide anyone. N.T. p. 610.

At the hearing, appellant, when asked to describe the way she was treated by the staff on Unit 310, responded;

> I felt like from the very beginning, they didn't welcome me. They were stand-offish. And I thought well, that's normal because you are new. But it continued. They were uncooperative. I would ask them to do something and they wouldn't listen.
>
> * * *
>
> I felt like I didn't even exist. Like I would talk to them. There was one psych aide that she behaved nice. And she was normal, more mature. And I didn't --- she didn't give me a hard time. The other ones act like --- they seem like they actually was out to give me a hard time.

N.T. pp. 610-611. Appellant testified that she complained to both Zechman and Long. N.T. pp. 612-613. Appellant noted that four days after she filed a written complaint alleging harassment by Long, she was the subject of a disciplinary investigation; the investigation did not result in discipline. N.T. pp. 618-621; Ap. Exs. 32, 33.

Appellant indicated that when she was assigned to Unit 310 in early May 2017, the Unit was reduced from three nurses to two. N.T. p. 624. When two or more nurses are assigned to a Unit, one would be designated as the Charge Nurse; the Charge Nurse would then serve as a first line supervisor and oversee the Unit. N.T. p. 623. A second nurse would then be designated the Medication Nurse. N.T. p. 624. Appellant testified that Belinda Gordner was normally the second nurse working with her on Unit 310; Gordner was the Charge Nurse in May and June of 2017. N.T. pp. 624, 626. Appellant was the Medication Nurse. N.T. p. 625.

Appellant testified that she was scheduled to begin serving as Charge Nurse in July; the schedule was advanced due to Gordner's vacation, beginning seven or eight days before the end of June. N.T. p. 626. Another RN did not work with appellant during Gordner's absence. N.T. p. 627. Appellant testified that on her return:

> I was very surprised because [Gordner] is a very nice person. But the first time she came back from vacation, I was glad to see her. And I ask her --- I had already had the first two hours of three observation sets. The first couple hours were already arranged. And I didn't have her down as one of the sitters. And I politely asked her if she would do the first shift count. Not first shift. I mean the second between shift, between second and third shift, do just the in-between, the change of shift count with second shift. Meaning she would go into the medication room.

N.T. pp. 627-628. According to appellant, Gordner said "no." N.T. p. 628.

Appellant indicated that patient M.S. was a difficult patient; she explained:

> [M.S.] is psychotic. She did a lot of vulgar language, and yelling, and not liking people. Rude.

N.T. p. 629. After her hip fracture, M.S. was prescribed morphine to be administered every four hours; on night shift, her doses were due at midnight and 4:00 a.m. N.T. p. 630. Appellant testified that M.S. sometimes refused the morphine; usually the midnight dose. N.T. p. 631. Appellant testified that she would encourage M.S. to take the medication; M.S. would sometimes still refuse. N.T. pp. 631-632.

Appellant acknowledged that she worked on Unit 310 during the third shift beginning at 11:00 p.m. on Tuesday, July 11, 2017. N.T. p. 633. Appellant was the only RN on duty that shift. N.T. p. 633. A second RN, although present that shift, was working as an aide, not as a nurse, at that time. N.T. p. 634. Three patients were on SLO that night. N.T. p. 634. Appellant testified that during her shift, sometime between 11:20 p.m. and 12:15 a.m., she went into M.S.' room and asked her if she was going to take the prescribed morphine; according to appellant, M.S. responded:

> She said no. I don't like you. Get out of here. I don't need it. I don't want it. And I don't need it.

N.T. p. 636. Appellant testified that despite encouragement, M.S. continued to refuse. N.T. p. 636. Appellant further stated that later, when she was writing a nurse's progress note:

> I was writing at the end of the shift, her SLO note. And I realized that right after I wrote the SLO note, that oh no, I

> forgot to mention about her narcotic. So I tried to put it up on top of the area before I signed my name.

N.T. pp. 637-638.

Appellant indicated that she had prepared a nursing progress note on M.S. at 0655 on July 12. N.T. pp. 640-641; AA Ex. 1, Attachment D-17, p. 2. When asked why she had made a notation stating that M.S. had rejected the midnight morphine dose but had accepted one at 4:00 a.m., appellant responded, "[b]ecause I wanted to squeeze it in there. And I was in a hurry at the end of a shift." N.T. p. 641.

Appellant noted a similar entry prepared on July 14 which she called a "late entry." N.T. p. 642; Ap. Ex. 12, p. 2. Appellant noted that she did not work on the nightshifts beginning on July 12 and July 13. N.T. p. 643. She instead noted that at 2330 on July 14, she prepared a late entry for July 12 at 0655 in which she again stated that that M.S. had refused the July 11, 2400 dose of morphine. N.T. p. 644. When asked why she prepared the statement, appellant testified:

> I did it because I remembered that I did this entry.
>
> * * *
>
> I actually went home. And that weekend, I remembered it. And I didn't feel comfortable about it. Nobody mentioned anything to me about this. When I came into work on 7/14 at 11:30, which is 2330 military time, I wrote this late entry to cover this.

N.T. p. 644. Appellant indicated that she was first questioned with regard to the matter on July 25. N.T. p. 645. Appellant noted that she subsequently sent a letter to Temple in which she adjusted her statement by stating that she was not sure whether she had the morphine with her at the time M.S. rejected medication. N.T. pp. 646-647, 649; Ap. Ex. 35, p. 2 of 7.

Appellant testified that the July 11-12, 2017 nightshift was "extremely busy." N.T. p. 650. She noted that it was the regular night off for Belinda Gordner, the other RN; Gordner was, in fact, at the Hospital but was working overtime on a different unit. N.T. pp. 650-651. Appellant also noted that that night she was responsible for preparing the Unit's Thymer Cart[8], a job which required that she remove the medications from the cart, count them and replace them in order based upon each of the Unit's 28 patients' MARs; according to appellant, this is a time-consuming task. N.T. pp. 651-653. Appellant testified that patient C.Y. returned to the Unit from a hospital[9] that night; this entailed additional duties, including a call to the doctor. N.T. pp. 654-656. Appellant testified that she contacted Zechman to ask for assistance but was told "[s]he couldn't provide [appellant] with anybody." N.T. p. 656.

Appellant testified that, contrary to earlier testimony claiming that appellant failed to check medication administration records prior to giving meds to a patient, she did check the MARs. N.T. p. 657. She explained:

> [a]fter I was done with the Thymer Cart, I leaf through every page of the MAR. This is how I do it all the time. And I use a yellow sticky because especially on Unit 310, the tabs didn't come out very well. So I used a yellow sticky for every patient that needed a medication for my shift or a glucometer --- or check glucometer reading and/or insulin.

N.T. p. 657.

[8] As described at the hearing, the Thymer Cart is sent to the Unit from the Hospital's Pharmacy and supplies the Unit with each patient's medications for the week. N.T. p. 651.

[9] C.Y. returned from the local hospital. N.T. p. 684.

Appellant denied the claim that on July 15 she had to be prevented by staff intervention from administering morphine to the wrong patient. N.T. pp. 660-661. In support of her statement, appellant discussed her actions as portrayed on video recorded by the appointing authority (AA Ex. 2b). According to appellant, the video[10] shows her leaving the medications room, carrying a sheet of paper in one hand and a syringe in the other; appellant refers to the paper as a census paper[11] and describes the syringe as containing a morphine solution to be administered to patient M.S. N.T. pp. 662-663.

Appellant presented the following testimony, explaining the actions taking place on the recording after she places the census sheet on a table in the hall:

> There wasn't any other staff available to take the census down. So I was going to have to leave the unit to take the census down. And I knew [Gordner] was in there. And even though I have M.S.' morphine solution in my hand, I stopped there to talk to [Gordner] to let her know that I had to leave the unit. I have to leave somebody know that I'm leaving the unit.
>
> * * *
>
> As soon as I opened up the door to talk to [Gordner], to let her know I'm going the leave, she's already interrupting me telling me no, you got the wrong room. You need to give it to M. She's two doors down. That you have the wrong person, wrong room, wrong person.
>
> * * *

[10] The exhibit includes two views covering the noted date and time period; one is captioned "front hall - south view" and the other "front hall – north view." Although appellant, during her testimony, does not clarify which view is being described, the Commission, having viewed both, is assuming that she is referring to the south view.

[11] Later during her testimony, appellant states that the census had to be delivered "to the front nursing office." N.T. p. 665. From context, this is presumably somewhere outside Unit 310.

> I was saying [Gordner], please, I am not here to give C.Y., M.S.' medication. I'm here to let you know that I have to leave the unit to deliver the census. But she kept it up. And then what I was doing was I go --- I push back by saying wow. I don't know where I am. I don't know who I am. I don't have no idea who's room this --- . Who am I? And I looked up on top of the door. Then I went and looked up on the top of the outside of the door because I am being sarcastic.
>
> * * *
>
> I'm being sarcastic. Because [Gordner] went on a rant. She just kept on and on and on. And she kept saying the same thing without listening to what I was trying to say. She kept on saying no, not this room. Not this patient, no. and she was looking at me as if like either I was a real dummy, or that she was scared. Like I was actually going to give it. And at the same time, actually somebody else is yelling up the hall at the same time saying the same thing. No, wrong room.

N.T. pp. 663-666. Appellant left that location and went to M.S.' room to administer the 2400 dose. N.T. p. 667. Appellant testified that, after leaving M.S.' room,

> I go back, because I don't think it registered to [Gordner]. So I'm trying to communicate and she goes back again. That's why I'm bopping my head back because as soon as she sees me, she's going on with this thing about me being in the wrong room.

N.T. p. 667. Appellant testified that, after retrieving the census, she left the unit to deliver the paper. N.T. pp. 670-671. Appellant denied ever having difficulty identifying M.S. or ever trying to give the morphine to C.Y or any other person. N.T. p. 671.

On cross-examination, appellant acknowledged that, during the period under review, the doctor's prescription directed that M.S. receive morphine every four hours. N.T. pp. 679-680, 687. Appellant acknowledged that following M.S.' initial refusal of the medication, appellant had time to try again but did not do so. N.T. p. 688. Appellant also explained that the notations on the MAR (AA Ex. 1, Attachment D-18-c) had been setup to include the 2400 and 0400 administrations of medication as part of the prior day's medications—*i.e.* July 11. N.T. pp. 691-693. It was noted that, with only one exception, the only nurse recording M.S. refusing the medication, was appellant. N.T. pp. 698-703.

On further cross-examination, appellant acknowledged her prior stipulation that she had allowed patient L.H. to self-administer a glucometer check. N.T. p. 740. Appellant acknowledged allowing several patients to do so; she further acknowledged that not all of the patients had physician's orders permitting them to do so. N.T. pp. 754-755. Appellant again denied having difficulty distinguishing patients. N.T. pp. 757-758.

Section 803 of the Civil Service Act states that, to be acceptable under the Act, a suspension must be based on "good cause." 71 P.S. § 741.803. While the phrase "good cause" is not defined in the Act, the Courts have noted that,

> the case law has interpreted "good cause" to mean that any personnel action carried out by the state must be scrutinized in the light of merit criteria, such as has the party failed to properly execute his duties, or has he done an act which hampers or frustrates the execution of same.

> In addition, the criteria must be job-related and in some rational and logical manner touch upon competence and ability.

Shade v. Pennsylvania State Civil Service Commission (Pennsylvania Department of Transportation) 749 A.2d 1054, 1057 (Pa. Commw. 2000) citing *Toland v. State Correctional Institution at Graterford, Bureau of Correction*, 95 Pa. Commw. 634, 638-639, 506 A.2d 504, 506 (1986) and *McCain v. Commonwealth, Department of Education, East Stroudsburg State College*, 71 Pa. Commw. 165, 454 A.2d 667 (1983). Having fully reviewed the transcript of the testimony taken at the hearing and all relevant evidence submitted by the parties in this appeal, we find that the appointing authority has established good cause to suspend appellant.

In support of our conclusion, we note that the appointing authority, through the testimony of Dalberto, introduced evidence establishing that, since at least the issuance of a January 2017 annual performance review, appellant had been made aware of supervisory criticisms of her job performance and the need to adhere to the Hospital's policies and procedures. N.T. pp. 386-393; AA Ex. 5. These performance issues have been coupled with Coleman's testimony regarding the following distinct incidents revealed through her review of video and nursing records:

1. that patient M.S. did not receive the medication scheduled for 2400 during the July 11-12, 2017 night shift;

2. that appellant during that July 11-12 shift wrote "between the lines" on patient M.S.' Progress Record;

3. that appellant, later during the same July 11-12 shift, allowed three patients to perform their own glucometer checks and administer insulin despite their lack of "orders to self-administer;"

4. that appellant allowed a patient to perform her own glucometer check and self-administer insulin on July 17, 2017;

5. that appellant left the medication room unattended and with the door open for more than three minutes on July 17, 2017;

6. that appellant, on July 15, 2017, went to the room of patient CY and was prevented, by staff intervention, from administering medication intended for another patient.

Testimony, from Buck, Gordner and Smith, and video recordings were presented to supplement Coleman's presentation. Credible testimony introduced through Dalberto and Burk indicates that the noted matters were considered in determining that appellant had violated the appointing authority policies and that she should be subject to a disciplinary suspension. This evidence is enough to establish the required *prima facie* case in support of the decision to suspend appellant.

The appointing authority's first two Charges—falsification and negligent abuse—are both based upon its conclusion that appellant did not, in fact, offer the medication. AA Bf. pp. 9-14. Appellant has admitted that she recorded M.S. as having "refused" a proffered medication; however in opposition to the appointing authority's claim that her notation was false, appellant has testified that

she did offer the medication but, as has occurred in the past, M.S. rejected the offer. Although Coleman testified to her belief that the appointing authority had video showing that no one entered M.S.' room with morphine during the earlier 2300 to midnight time period (N.T. pp. 133-134), the appointing authority neither presented that video at the hearing nor explained why it could not be presented; instead video showing the medication room during that time period was shown despite the fact that appellant had already informed the appointing authority, prior to and during the PDC (Ap. Ex. 35; AA Ex. 4) that she may not have had the medication with her when she spoke with M.S. Appellant having presented the only direct evidence on the subject of what occurred between her and M.S. between 2300. and midnight on July 11, 2017, the appointing authority cannot prevail unless appellant is deemed less-than-credible. The appointing authority, however, has presented an argument challenging appellant's credibility; it has also introduced an apparent challenge to appellant's argument.

As a challenge to appellant's credibility, the appointing authority has noted what it has described as "[a]ppellant's varied, and inconsistent, explanations" of her actions. AA Bf. p. 10. In opposition to that description, appellant has attempted to explain the evolution of her statements regarding her notation of the fact that M.S. did not receive the July 11-12 midnight medication:

1) appellant admitted that when she spoke with Coleman on July 25, 2017, she told her she had taken the midnight medication with her to M.S.' room—appellant however contends that she made this statement based upon her general practice (N.T. pp. 83, 645-646);

2) appellant acknowledged submitting a written statement, dated August 2, 2017 (AA Ex. 10), on which she indicated that she had the medication

with her but returned it when M.S. refused to take it—appellant again contends that this statement was based on her regular practice (N.T. pp. 726-737);

3) appellant submitted a written statement, dated August 11, 2017 (Ap. Ex. 35), on which she acknowledged that she "may or may not have taken the pain narcotic to [patient M.S.'] room . . ."—appellant argues that the written statement was based "upon further reflection" (N.T. p. 723).

AA Bf. pp. 10-13; Ap. Bf. pp. 17-20. Appellant contends that since the August 11 letter, she "has maintained that she did not take the morphine to M.S.' room." Ap. Bf. p. 18. The Commission however has deemed the appointing authority's observations sufficient to persuade us that the convenient changes to appellant's recollection of events lacks credibility.

Further undermining appellant's argument has been the appointing authority's unstated but apparent view that for a proffer of medication to be deemed a genuine attempt to administer medication, the individual making the attempt must have the medication prepared and immediately available to be given. We agree. On that basis, appellant's assertion of mere discussion with the patient as equivalent to an attempt to administer the medication must be dismissed. On that basis, we have found the appointing authority's charges, of falsification and negligent abuse, valid; it is our view that the appointing authority's Charges 1 and 2, even had they stood alone, would suffice as "good" cause for the herein-challenged five-day suspension.

The written notice alleges, as Charge 3A, that appellant, on July 17, 2017 committed several infractions; appellant has not challenged these allegations. During the PDC, appellant admitted the charged conduct. N.T. p. 327; AA Ex. 4,

p. 3. At the hearing, appellant again acknowledged that conduct through the following stipulation:

> On July 17, 2017 at approximately 0630 you left consumer L.H. unattended and did not supervise her performing a glucometer check and you did not supervise her self-administering insulin. You left the medication room for approximately 3 minutes and 10 seconds while the consumer self-administered medication. You did not have the Medication Administration Record (MAR) in the medication room. The consumer did not have an order to perform glucometer checks or administer insulin under a nurses' supervision.

N.T. pp. 22-24; Comm. Ex. I. At the hearing, the parties further stipulated that leaving the patient unsupervised was a violation of the appointing authority's one-on-one policy. N.T. pp. 67-69. Accordingly, we find that the appointing authority's Charge 3A has been supported by credible evidence; we further find that, even had it stood alone, appellant's conduct would have been deemed "good" cause for suspension.

Charge 3B alleges that appellant, on the July 11-12, 2017 shift, failed to adhere to the appointing authority's documentation process by inserting her initial statement regarding M.S.' medications during that shift, in the wrong place. During her PDC (N.T. p. 328) and at the hearing (N.T. pp. 640-641) appellant acknowledged the action. She stated that the infraction was due to her hurry; appellant noted, and the appointing authority acknowledged, that on her next workday, she properly prepared a late entry on the same subject. N.T. pp. 328, 642-645. Appellant having, however, admitted the improper action, we find that the appointing authority's Charge 3B has been supported by credible evidence.

Charge 3C alleges that appellant, on the morning of July 12, 2017: 1) administered medication without referencing the MAR; 2) allowed three patients to self-perform glucometer checks and self-administer insulin; 3) did not supervise the three while they administered their insulin; and 4) did not change gloves between any of the noted consumer contacts. Comm. Ex. A, p. 2. In support of the charge, the appointing authority has again cited the testimony of Coleman, based upon her review of relevant video. N.T. pp. 79-82; AA Bf. pp. 16-17. At the hearing, appellant testified that she did, in fact, review the patients' MARs and that of the three patients, one had a self-administration order and a second had a self-administration order for use of the glucometer; appellant further argues that the appointing authority, by not presenting documentary support for its claim, failed to meet its burden on the self-administration issue. N.T. pp. 657-659; Ap. Bf. pp. 23-24. She further notes that her failure to change gloves, while the patients self-administered their tests and medications, involved no contact between her and the patients. Ap. Bf. p. 24. Appellant, having failed to challenge the essential facts underlying the charge—*i.e.,* her failure to in any way directly supervise the three patients during their handling of medications—has largely admitted the Charge. Accordingly, appellant's challenge to Charge 3C has been dismissed; we further find that, even had it stood alone, appellant's conduct would have been deemed "good" cause for suspension.

Charge 3D alleges that appellant, at 2344 (11:44 p.m.) on July 15, 2017, entered patient CY's room to administer "oral morphine solution" but, through the intervention of co-workers, was prevented from medicating the wrong patient. Comm. Ex. A, p. 2. Coleman's relevant testimony was based upon her observation of video focused upon the hallway outside C.Y.'s room; her testimony was buttressed by that of Gordner and Smith. Gordner testified that when appellant came

to C.Y.'s room, it was with the intent to medicate C.Y.; Smith testified that she was down the hall at the time and saw appellant enter the room with the medication syringe and heard Gordner's elevated voice. N.T. pp. 260-261, 302-304. Appellant testified that she went to C.Y.'s room to speak with Gordner, not to medicate C.Y. N.T. pp. 663-666. Based, in part, on our own review of the relevant video recordings, we find appellant's explanation of her actions and intent credible; appellant clearly did not enter the room, but instead apparently sought to engage Gordner. AA Ex 2b, ch01_20170715231405 at 23:44:00 – 23:48:55; AA Ex. 2b, ch02_20170715230000-23:44:00 - 23:48:55; Ap. Ex. 2, 23:44:00 – 23:48:45. Accordingly, we find that the appointing authority has failed to establish its Charge 3D.

Based upon our review of the record, we find that the appointing authority has presented evidence sufficient to establish its Charges 1, 2, 3A, 3B, and 3C. To our minds, these charges constitute "good cause" for the suspension of appellant. The appointing authority has established that the Hospital is a residential facility for the treatment of patients; appellant, as a Registered Nurse, was responsible for the care of a number of those patients. Appellant was the sole Registered Nurse on duty on the Unit at the time of some of the charged incidents; appellant, as a long-time employee, knew or should have known of the potential harm to those patients her actions could have caused. Appellant's actions justify the imposition of a five-day suspension.

At this point we note that, in addition to challenging the substance of the appointing authority's claims, appellant has alleged discrimination due to her disability and/or in retaliation for her complaints of harassment and discriminatory treatment. Ap. Bf. pp. 3-12. As an action brought under Section 951(b) of the Civil

Service Act, the initial burden has been placed upon appellant to establish a *prima facie* case in support of her allegations—*i.e.*, she was required to introduce evidence that, if believed and otherwise left unexplained, indicates that more likely than not discrimination has occurred. *Henderson v. Commonwealth, Office of the Budget*, 126 Pa. Commw. 607, 614, 560 A.2d 859, 863 (1989). Appellant has failed to meet that standard.

The only evidence on the subject establishes that the decision to suspend appellant was made by a panel consisting of the Hospital's Chief Operating Officer, its CEO and its Nursing Director (N.T. pp. 384-385, 444); two of the three—Dalberto and Burk—testified at the hearing. Appellant has presented nothing which, in any way, disputes their claimed reliance upon the PDC report (AA Ex. 4; Ap. Ex. 19) as the basis for their determination; appellant has instead: 1) challenged the quality of the investigation performed by Coleman; and 2) asserted the annual EPR and other related performance commentaries as evidence of disparate treatment. Appellant, however, has not claimed that the PDC report was affected by discrimination; she has instead acknowledged, both during the PDC and at the hearing, the accuracy of much of the conduct discussed in the PDC report. To our minds, appellant has failed to show that Dalberto or Burk were aware of her claimed disability and complaints at the time they made the suspension decision. We are therefore unable to rule that she has produced the required affirmative evidence in support of her *prima facie* claim.

Appellant's claim of retaliation has similarly been dismissed. As with her allegation of discrimination, appellant, having failed to attribute any knowledge of her complaints to Dalberto or Burk, it is our view that she has shown no causal connection between those complaints and the decision to impose the herein challenged disciplinary action. Accordingly, we enter the following

CONCLUSIONS OF LAW

1. The appointing authority has presented credible evidence to establish that the suspension of appellant was for good cause sufficient under Section 803 of the Civil Service Act, as amended.

2. Appellant has failed to introduce credible evidence sufficient to establish that her suspension was imposed due to discrimination violative of Section 905.1 of the Civil Service Act, as amended.

ORDER

AND NOW, the State Civil Service Commission, by agreement of two of its members,[12] dismisses the appeal of Theresa R. Zajac challenging her suspension from regular Registered Nurse employment with the Danville State

[12] Chairman Teresa Osborne, who took office March 22, 2019, did not participate in the discussion or decision on this appeal.

Hospital, Department of Human Services and sustains the action of the Danville State Hospital, Department of Human Services in the five-day suspension of Theresa R. Zajac from regular Registered Nurse employment effective July 20, 23, 24, 25 and 28, 2017.

State Civil Service Commission

Gregory M. Lane
Commissioner

Bryan R. Lentz
Commissioner

Mailed: September 3, 2019