IOWA WORKFORCE DEVELOPMENT
UNEMPLOYMENT INSURANCE APPEALS

68-0157 (9-06) - 3091078 - EI

MARCIA A SMITH
Claimant

CARE INITIATIVES
Employer

APPEAL NO. 11A-UI-02992-JTT

ADMINISTRATIVE LAW JUDGE DECISION

OC: 01/16/11
Claimant: Appellant (2)

Section 96.5(2)(a) – Discharge for Misconduct

STATEMENT OF THE CASE:

Marcia Smith filed a timely appeal from the March 7, 2011, reference 01, decision that denied benefits. After due notice was issued, a hearing was held on April 1, 2011. Ms. Smith participated. Jacqueline Jones of TALX represented the employer and presented testimony through Dawnetta Ware, director of nursing. Exhibits One through Seven were received into evidence.

ISSUE:

Whether the claimant was discharged for misconduct in connection with the employment that disqualifies the claimant for unemployment insurance benefits.

FINDINGS OF FACT:

Having reviewed all of the evidence in the record, the administrative law judge finds: The employer operates the Ridgewood Nursing and Rehab Center in Ottumwa, where Marcia Smith was employed as a full-time licensed practical nurse from May 2010 until January 14, 2011, when Dawnetta Ware, director of nursing, suspended her pending further investigation and a decision regarding whether she would be allowed to continue in the employment. On January 19, 2011, Ms. Ware discharged Ms. Smith from the employment for negligence. Ms. Ware was Ms. Smith's immediate supervisor. Ms. Smith was assigned to the 2:00 p.m.-to-10:00 p.m. shift. Ms. Smith obtained her practical nursing license in April 2009.

The incident that triggered the discharge occurred on January 5, 2011. On the evening of January 5, Certified Medication Aide Carrie Chase notified Ms. Smith that a particular resident had complained of mouth pain at dinner. Ms. Chase also notified Ms. Smith that she had noted pus on the resident's lip. In response to the report from Ms. Chase, Ms. Smith, the nurse responsible for the resident's care, attempted to assess the resident. The resident refused to open her mouth so that Ms. Smith could look inside. Ms. Smith spent 15-20 minutes taking the resident's vital signs and attempting to look inside the resident's mouth. Ms. Smith was aware that the resident had the right to refuse treatment. Ms. Smith charted the resident's vital signs but did not chart anything regarding the report Ms. Chase made to her or the resident's refusal to let her look in her mouth. Ms. Smith was under the belief that she need not document the

resident's refusal to be assessed because such refusals were not out of the ordinary for that resident. Ms. Smith did not notify a physician or the resident's family of the resident's complaint about pain in her mouth or the resident's refusal to allow Ms. Smith to assess the situation. Ms. Smith's attempt to assess the resident's mouth occurred within the last hour of Ms. Smith's shift. Ms. Smith gave a shift report to the overnight nurse and mentioned the report she had received regarding the resident's mouth pain, and the resident's refusal to allow her to look in her mouth, and the fact that she had not observed anything out of the ordinary regarding the resident's mouth.

Dawnetta Ware, director of nursing, was away from the facility on January 5 and 6, 2011. When Ms. Ware returned to the facility on January 7, Certified Nursing Assistant Terri Wilburn, Certified Medication Aide Carrie Chase, and Nurse Clarissa Cabbosart each approached Ms. Ware to express concern regarding the resident's mouth condition. Ms. Wilburn and Ms. Chase both indicated they had alerted Ms. Smith regarding the patient's complaint of pain on January 5. Nurse Clarissa Cabbosart told Ms. Ware that she had worked the night shift on January 6, had seen the pus on the resident's lip, had done assessment of the resident's mouth, and had contacted the doctor and the resident's family.

After Ms. Ware spoke to Ms. Wilburn, Ms. Chase, and Nurse Cabbosart, she telephoned Ms. Smith. Ms. Smith acknowledged that she had received the report that the resident was complaining of pain, had attempted to assess, but had not done an assessment because the resident had refused to open her mouth. When Ms. Ware asked why Ms. Smith had not documented the concern, Ms. Smith indicated that she had forgotten to do so. Ms. Smith did mention that she gave a report to the incoming overnight nurse.

On January 8, Ms. Smith did do her own assessment of the resident with the mouth issue and noted multiple issues inside the resident's mouth. Ms. Smith also discovered a physician's order for treatment of the mouth issue, which order had been written out on January 7, but had then been misplaced by another employee in a different resident's chart. The resident in question was hospitalized on January 8 with a mouth infection and required IV antibiotics to treat the mouth infection.

Ms. Ware allowed Ms. Smith to continue working until January 14, when she suspended Ms. Smith. Before suspending Ms. Smith, Ms. Ware issued written reprimands regarding the failure to properly assess, failure to document, and failing to notify the doctor and family in connection with the January 5 incident. On January 13, a resident assigned to Ms. Smith's care suffered a fall at the facility. Another nurse was the first to respond. Ms. Smith did not document anything regarding the resident's fall and did not contact the doctor or the resident's family. Before Ms. Ware suspended Ms. Smith on January 14, she issued a written reprimand to Ms. Smith for the January 13 failure to chart and failure to notify a doctor.

Ms. Smith's obligation to properly assess, chart, and notify the doctor regarding a resident's care were part of her training as a nurse, her training in the employment, and appeared as provisions of the written job description the employer had her sign and provided to her at the start of the employment.

On October 12, 2010, Ms. Ware had issued a written reprimand to Ms. Smith for failure to sign and date a new admission assessment, failure to complete a "skin sheet" regarding a red area on a resident's leg, and failure to reduce a doctor's verbal order for coumadin to writing. This admission was the first one Ms. Smith had completed. The nurse who ordinarily handled such matters was gone. Ms. Smith charted part of what was required, but then neglected to sign the document.

Ms. Ware completed her investigation of the January 5 incident on January 18 and had Ms. Smith appear for a meeting on January 19, at which time Ms. Ware discharged Ms. Smith from the employment. Prior to discharging Ms. Smith from the employment, Ms. Ware reported the January 5 incident to the Iowa Department of Inspections & Appeals as a denial of critical care.

REASONING AND CONCLUSIONS OF LAW:

Iowa Code section 96.5-2-a provides:

> An individual shall be disqualified for benefits:
>
> 2. Discharge for misconduct. If the department finds that the individual has been discharged for misconduct in connection with the individual's employment:
>
> a. The individual shall be disqualified for benefits until the individual has worked in and has been paid wages for insured work equal to ten times the individual's weekly benefit amount, provided the individual is otherwise eligible.

871 IAC 24.32(1)a provides:

> Discharge for misconduct.
>
> (1) Definition.
>
> a. "Misconduct" is defined as a deliberate act or omission by a worker which constitutes a material breach of the duties and obligations arising out of such worker's contract of employment. Misconduct as the term is used in the disqualification provision as being limited to conduct evincing such willful or wanton disregard of an employer's interest as is found in deliberate violation or disregard of standards of behavior which the employer has the right to expect of employees, or in carelessness or negligence of such degree of recurrence as to manifest equal culpability, wrongful intent or evil design, or to show an intentional and substantial disregard of the employer's interests or of the employee's duties and obligations to the employer. On the other hand mere inefficiency, unsatisfactory conduct, failure in good performance as the result of inability or incapacity, inadvertencies or ordinary negligence in isolated instances, or good faith errors in judgment or discretion are not to be deemed misconduct within the meaning of the statute.

The employer has the burden of proof in this matter. See Iowa Code section 96.6(2). Misconduct must be substantial in order to justify a denial of unemployment benefits. Misconduct serious enough to warrant the discharge of an employee is not necessarily serious enough to warrant a denial of unemployment benefits. See Lee v. Employment Appeal Board, 616 N.W.2d 661 (Iowa 2000). The focus is on deliberate, intentional, or culpable acts by the employee. See Gimbel v. Employment Appeal Board, 489 N.W.2d 36, 39 (Iowa Ct. App. 1992).

While past acts and warnings can be used to determine the magnitude of the current act of misconduct, a discharge for misconduct cannot be based on such past act(s). The termination of employment must be based on a current act. See 871 IAC 24.32(8). In determining whether the conduct that prompted the discharge constituted a "current act," the administrative law judge considers the date on which the conduct came to the attention of the employer and the date on

which the employer notified the claimant that the conduct subjected the claimant to possible discharge. See also Greene v. EAB, 426 N.W.2d 659, 662 (Iowa App. 1988).

Allegations of misconduct or dishonesty without additional evidence shall not be sufficient to result in disqualification. If the employer is unwilling to furnish available evidence to corroborate the allegation, misconduct cannot be established. See 871 IAC 24.32(4). When it is in a party's power to produce more direct and satisfactory evidence than is actually produced, it may fairly be inferred that the more direct evidence will expose deficiencies in that party's case. See Crosser v. Iowa Dept. of Public Safety, 240 N.W.2d 682 (Iowa 1976).

Ms. Smith, through her testimony, attempts to minimize her responsibility for what went wrong with the resident with the mouth infection and attempts to minimize her responsibility for charting and following up on the January 13 fall. On the other hand, the employer appears willing to assign more responsibility to Ms. Smith than perhaps is due for what went wrong with the resident with the mouth infection. Ms. Smith was clearly negligent for failing on January 5 to document the report she had received concerning the resident's complaint of pain and for failing to chart the resident's refusal of assessment. Ms. Smith's assertion that she did not need to document the report made to her because it did not involve an assessment made by her defies common sense and reason. A primary purpose of medical charting is communication between staff. By failing to chart the concern that had been brought to her attention, Ms. Smith eliminated one of the primary lines of communication concerning the resident's care.

Ms. Smith's assertion that she did not need to document the resident's refusal to have her mouth assessed because refusals were not out of the ordinary for that resident also defies common sense and reason because, again, the failure to document the situation eliminated a primary means of communication concerning the resident's care. In some respects, Ms. Smith's approach appears to be that of not seeing the forest for the trees. To Ms. Smith's credit, she did give a shift report to the overnight nurse regarding the resident's mouth issues. The employer failed to present evidence to indicate otherwise. The overnight nurse apparently also failed to chart the concern or assess the resident's mouth. Apparently, a nurse was aware of the issue on January 7 and obtained a physician's order, but then the order was misplaced, again hindering both communication amongst the nursing staff and effectively addressing the resident's care. The situation starts to look more and more like a systemic issue for which Ms. Smith cannot bear sole blame.

Ms. Smith, to her credit, did make a proper assessment of the resident on January 8, followed up with a physician and the resident's family, and this apparently led to the resident being hospitalized.

Ms. Smith's failure to chart anything regarding the resident fall, failure to notify a doctor or family, and failure to at least see whether her colleague did any of these things also involved negligence on the part of Ms. Smith.

The incident from October involved some carelessness on the part of Ms. Smith, but at least some portion of the incident was attributable to Ms. Smith's inexperience doing the admits.

Despite the incidents of negligence and carelessness discussed above, the evidence does not present a pattern of negligence of negligence so recurrent as to indicate a willful or wanton disregard of the employer's interests. Though the decision to discharge Ms. Smith was within the employer's discretion, the evidence does not establish misconduct rising to the level of that which would disqualify Ms. Smith for unemployment insurance benefits. Accordingly, Ms. Smith

is eligible for benefits, provided she is otherwise eligible. The employer's account may be charged for benefits paid to Ms. Smith.

DECISION:

The Agency representative's March 7, 2011, reference 01, decision is reversed. The claimant was discharged for no disqualifying reason. The claimant is eligible for benefits, provided she is otherwise eligible. The employer's account may be charged.

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James E. Timberland
Administrative Law Judge

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Decision Dated and Mailed

jet/kjw