IOWA WORKFORCE DEVELOPMENT
UNEMPLOYMENT INSURANCE APPEALS

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

JENNIFER A ARKLAND
Claimant

OPPORTUNITY VILLAGE
Employer

APPEAL NO. 17A-UI-00095-JTT

ADMINISTRATIVE LAW JUDGE DECISION

OC: 12/11/16
Claimant: Appellant (1)

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

STATEMENT OF THE CASE:

Jennifer Arkland filed a timely appeal from the December 27, 2016, reference 01, decision that disqualified her for benefits and that relieved the employer of liability for benefits, based on the claims deputy's conclusion that Ms. Arkland was discharged on December 7, 2017 for wanton carelessness in performing her work. After due notice was issued, the appeal hearing commenced on February 7, 2017, continued on February 15, 2017 and concluded on February 22, 2017. Ms. Arkland participated personally and was represented by attorney Stuart Cochrane. Attorney Kendra Simmons represented the employer. The following people testified: Linda Smith, Vicki Freeman, Bonnie Hagen, Carol Hillebrand, Monica Ver Helst, Amy Atchison, Angie Ingraham, Maureen Seamonds, Christy Headlee and Jennifer Arkland. Exhibits 1, 2, 3, 5 through 20, A and B 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: Opportunity Village provides a variety of services in support of individuals with disabilities. The agency provides residential services. The agency operates a non-licensed Home and Community Based Services residence on Elm Street in Webster City. Five adult males live at the residence. Opportunity Village staff provides 24-hour support services to those disabled men. Those services include storing and administering prescribed medication. One man, NS, has a gastrostomy tube and receives liquid medications through his g-tube. Those liquid medications include hydrocodone. Hydrocodone is an opiate-based narcotic and a Schedule II controlled substance under Iowa law.

Jennifer Arkland, R.N., began her employment in May 2014 and initially worked as an on-call nurse at the Elm Street residence. In July 2014, Ms. Arkland became the supervisor of the Elm

Street residence. Ms. Arkland remained the supervisor at the Elm Street residence until the employer suspended her on December 1, 2016 and discharged her on December 7, 2016.

Ms. Arkland became a registered nurse in 2010. Before Ms. Arkland began the employment at Opportunity Village, she received training as part of her nursing studies and nursing practice regarding the nursing standards for handling narcotics. Before Ms. Arkland began the employment, she was aware that nursing standards required that narcotics be "double locked," that is, that the narcotic be locked in a container and that the container be locked inside some other controlled space, whether that space was a cupboard or a room. Before Ms. Arkland began the employment at Opportunity Village, she was aware that nursing standards required that a narcotic count be performed at the beginning and end of a shift, that destruction of a narcotic was to involve two staff members, and that the destruction of a narcotic should occur via dumping the narcotic into an absorbent solid such as cat litter or used coffee grounds.

At the time Ms. Arkland began working at the Elm Street residence, she was surprised to learn that narcotic medications were not double-locked at that location. The practice at that time was to secure the medications in a locked closet without securing them in another locked container within the closet. When Ms. Arkland asked about the basis for the relaxed medication storage protocol, one or more of her superiors told her that the relaxed medication storage protocol was in keeping with the Elm Street residence being home to the five men who lived there and in keeping with the idea that a person would not usually double lock prescribed medications within their home. Ms. Arkland repeated this explanation throughout her employment to new nurses and non-nurse staff who questioned the lax medication storage protocol.

At the time Ms. Arkland became supervisor at the Elm Street location, only nurses were allowed to distribute prescribed medications and only nurses had access to the key that unlocked the closet in which the medications were stored. After Ms. Arkland became supervisor at the Elm Street location, the employer elected to discontinue staffing the residence with a nurse during the overnight hours. Instead, the employer began to assign non-nurse staff to work the overnight hours at Elm Street. Ms. Arkland remained on call during the overnight hours in a case a nurse was needed. The employer trained non-nurse direct care staff to function as "medication managers" so that they could distribute medications to the Elm Street residents. Much of this training occurred off-site through a certification program. Ms. Arkland was responsible for ensuring that the medication managers handled medications in accordance with Opportunity Village protocol.

In connection with the employer's transition to using medication managers to pass medications, Ms. Arkland further relaxed the medication storage protocol at the Elm Street residence. Because so many employees now had access to the key to the medication closet, Ms. Arkland authorized staff to simply leave the key in door lock or somewhere nearby where it would be readily available. In other words, Ms. Arkland implemented a change to the protocol whereby the medications, including narcotics, were no longer secured at all. It was this lax set-up that enabled one or more of the staff to tamper with and steal about 27 ounces of resident N.S.'s liquid hydrocodone over the course of several months in 2016.

In September 2016, Christy Headlee, L.P.N., was about to dispense some of N.S.'s liquid hydrocodone to him when she noticed that the liquid medication did not look right. Ms. Headlee observed that the liquid medication appeared to have particles floating in it. Ms. Headlee telephoned Ms. Arkland, who was at home at the time. Ms. Arkland directed Ms. Headlee to set the container of hydrocodone aside so that Ms. Arkland could follow up on the matter the next day. Ms. Headlee and Ms. Arkland assumed that the medication had degraded and, thereby, expired. Ms. Arkland disposed of the medication the next day by dumping the remaining

hydrocodone down a sink drain, rather than disposing of the narcotic in cat litter or used coffee grounds. Ms. Arkland did not document the problem with the medication, the loss of the medication, or the steps that she took to discard the medication.

On November 20, 2016, Ms. Headlee was again preparing to dispense some of N.S.'s liquid hydrocodone to him when she observed the container was almost empty. Ms. Headlee knew that a new bottle of hydrocodone had recently been ordered. Ms. Headlee checked to see how many times N.S. had received doses of hydrocodone since the refill and observed that the amount of the drug that was gone from the bottle greatly exceeded the amount of medication that had been dispensed to N.S. Ms. Headlee observed that the contents of the hydrocodone container smelled like cough syrup. Ms. Headlee noticed a bottle of over-the-counter cough syrup next to the hydrocodone bottle. Ms. Headlee called Ms. Arkland. Ms. Arkland instructed Ms. Headlee to place the bottle of hydrocodone in Ms. Arkland's office because there was no place to secure the container.

On November 21, Ms. Arkland observed that the hydrocodone appeared to have been tampered with and arranged for the issuing pharmacy to test the hydrocodone. The pharmacist confirmed that the substance in the hydrocodone bottle was cough syrup and told Ms. Arkland that Ms. Arkland was obligated to notify the police because a felony had been committed. Ms. Arkland notified the police and notified Vicki Freeman, Team Coordinator.

At that point, Ms. Freeman, Linda Smith, Regional Director, and Bonnie Hagen, Team Leader, commenced their investigation into the matter. The employer was unable to discovery which employee, or employees, had tampered with and stolen N.S.'s hydrocodone. As the employer began interviewing employees about the incident, the employer gained a clearer understanding of how lax the medication storage protocol had become under Ms. Arkland's supervision of nurses, medication managers, and other non-nurse staff. The employer interviewed about a dozen employees and concluded the investigation by interviewing Ms. Arkland on December 1, 2017. During the interview, Ms. Arkland indicted that she suspected two employees of being responsible for the tampering and theft. Ms. Arkland also told her superiors that money that had also been kept with the medications had been stolen.

In the course of investigating the matter, the employer compared the record of hydrocodone dispensed to N.S. with the quantity of hydrocodone that the staff had acquired from the pharmacy for N.S. Ms. Arkland had never performed such an audit. Through the employer's audit, the employer determined that 795 milliliters, or the equivalent of about 27 ounces, of the 1080 ml of liquid hydrocodone obtained for N.S. since January 23, 2016 was unaccounted for.

The employer discharged Ms. Arkland on December 7, 2017. In the discharge document, the employer set forth the basis for the discharge as follows:

> Jennifer had responsibility for and failure to set up and manage an adequate system of medication storage, administration and disposal as required in Opportunity Village policy code #4.29.01, HEALTH CARE AND MEDICATION ADMINISTRATION FOR NON-LICENSED SETTINGS. This failure put the agency, those served, and staff in vulnerable situations. This failure was identified during an investigation of missing Schedule II drugs in the Elm St. site.

The employer had provided Ms. Arkland with a copy of the medication administration policy in June 2014. At that time, Ms. Arkland acknowledged in writing that the policy had been reviewed with her. During her interview on December 1, 2016, Ms. Arkland told the employer that she

had received the policy, but had not read it. Paragraph 7 of the written policy provided as follows:

> If a person served is taking a physician ordered controlled substance (Schedule II) the following procedure must be followed:
>
> If at all possible, Schedule II meds are to be delivered to the home of the person served by the dispensing pharmacy. If this is not possible, then the person served should accompany the staff to/from the pharmacy and be in possession of the Schedule II med from the pharmacy to their home.
>
> The medication must be kept in a locked box within another locked container, cupboard or room.
>
> A Schedule II Inventory Control Record must be kept.
>
> A count of this medication by 2 qualified medication staff (a Nurse, Medication Aide and/or Medication Manager). These counts must be recorded on the Schedule II Inventory Control Record. The assigned Team Leader, SCL Supervisor, or Outcome Coordinator will be responsible for making sure the twice weekly counts are completed and recorded. If different days for counting are needed, the Health Services Supervisor must be notified. If the counting day falls on a holiday, the count may be done the day before or day after.
>
> Daily counting will be done at medication administration times prior to administering the medications by the medication staff (a Nurse, Medication Aide or Medication Manager)
>
> All counts must be recorded on the Schedule II Inventory Control Record.
>
> The Health Services Supervisor has the discretion to require more frequent counts as she/he feels is necessary depending on the medication prescribed and/or situation.
>
> If at any time the count of the Schedule II medication supply does not reconcile between the Schedule II Inventory Control Record and the amount of medication in the home, the Services Director and Health Services Supervisor must be notified for further instructions. An Incident Report will be immediately filled out by the staff finding the discrepancy and submitted to administration for review and documentation. The Health Services Supervisor will institute more frequent counts until the investigation is completed and appropriate corrective actions have been taken and implemented.
>
> Any suspicion of theft of medications must be reported by the end of the working shift, per Opportunity Village Prevention and Abuse policy.
>
> Upon discontinuation of a controlled substance by physician:
> If the pharmacy will accept the unused medication, it will be taken to the pharmacy for disposal. This information must be documented on the Schedule II Inventory Control Record and kept with the medical file.
> If the pharmacy will not dispose of the unused medication, it will be destroyed by a licensed health care professional (RN, LPN) and one other responsible adult staff. The disposal procedure will be done as stated in #5. The Schedule II Inventory Control Record is to be filled out by the licensed health care professional destroying the unused medications and this record will be retained in the medical file.
>
> Upon discharge from services, the unused Schedule II medication shall be sent with the legally responsible person upon the written order of the physician and the disposition of medications documented on the Schedule II Inventory Control Record and Health Care Notes and kept with the medical file.

Paragraph 5 of the policy addressed destruction of medications as follows:

> Upon discontinuation of a medication, if the pharmacy will accept the discontinued medication, it will be taken to the pharmacy for disposal. In the event that the pharmacy will not accept the discontinued medication, the medication must be disposed of by mixing in kitty litter or used coffee grounds, then placed in a sealable bag or container and put in the trash. This must be done by 2 qualified medication staff (a certified Medication Aide, Medication Manager or a nurse). Disposal of medication must be done within 7 working days and documented on the client's medication disposition record.

Prior to the December 1, 2016 suspension, Ms. Arkland had not been disciplined in the course of the employment.

REASONING AND CONCLUSIONS OF LAW:

Iowa Code § 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.

Iowa Admin. Code r. 871-24.32(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.

This definition has been accepted by the Iowa Supreme Court as accurately reflecting the intent of the legislature. *Huntoon v. Iowa Dep't of Job Serv.,* 275 N.W.2d 445, 448 (Iowa 1979).

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).

The weight of the evidence in the record establishes misconduct in connection with the employment based on a pattern of carelessness and negligence. The weight of the evidence supports Ms. Arkland's assertion that the Elm Street staff did not adhere to the employer's medication administration policy for non-licensed facilities at the time Ms. Arkland began her employment or at the time she became a supervisor. In other words, narcotics were not being double-locked at that time. However, at the time Ms. Arkland became supervisor, the medications, including the narcotic medications, were still being secured in the locked closet with the nurse on duty possessing the key. Ms. Arkland changed that protocol or negligently allowed subordinate staff to essentially change the medication storage protocol so that the medication, including the narcotics, became completely unsecured. Through this gross negligence on the part of Ms. Arkland, she made it incredibly easy for a thief and/or addict to access, tamper with, and steal N.S.'s hydrocodone. Through Ms. Arkland's ongoing negligence in failing to perform any meaningful audit of the narcotic medication on hand, Ms. Arkland continued, over the course of several months, to make it incredibly easy for a thief and/or addict to access, tamper with, and steal N.S.'s hydrocodone. In September 2016, Ms. Arkland knew full well that she disposing of the hydrocodone in an unauthorized manner. Through her training as a nurse, through her prior nursing practice, and through the employer's written policy, Ms. Arkland knew throughout her time as a supervisor that she was being negligent in her handling of the narcotic medication. Ms. Arkland knew or should have known that she was placing her nursing license at risk, placing the licenses of her fellow nurses at risk, placing the dependent adult residents in her care at risk, and exposing the employer to increased risk. Ms. Arkland's ongoing negligence demonstrated an intentional and substantial disregard of the employer's interests.

Based on the evidence in the record and application of the appropriate law, the administrative law judge concludes that Ms. Arkland was discharged for misconduct. Accordingly, Ms. Arkland is disqualified for benefits until she has worked in and been paid wages for insured work equal to ten times her weekly benefit amount. Ms. Arkland must meet all other eligibility requirements. The employer's account shall not be charged for benefits.

DECISION:

The December 27, 2016, reference 01, decision is affirmed. The claimant was discharged for misconduct. The claimant is disqualified for unemployment benefits until she has worked in and paid wages for insured work equal to ten times her weekly benefit allowance. The claimant must meet all other eligibility requirements. The employer's account shall not be charged for benefits.

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James E. Timberland
Administrative Law Judge

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Decision Dated and Mailed

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