STATE OF IOWA
BEFORE THE PUBLIC EMPLOYMENT RELATIONS BOARD

AMY RYAN, Appellant, and STATE OF IOWA (DEPARTMENT OF HUMAN SERVICES), Appellee.	CASE NO. 100727

PROPOSED DECISION AND ORDER

Appellant Amy Ryan filed this state employee disciplinary appeal with the Public Employment Relations Board (PERB) pursuant to Iowa Code section 8A.415(2)(*b*) and PERB rule 621—11.2(3) following a third-step response by the director of the Iowa Department of Administrative Services (DAS) denying her challenge of disciplinary action. Ryan is employed by the State of Iowa at the Department of Human Services – Glenwood Resource Center (DHS-GRC) as a resident treatment supervisor. Ryan alleges the State did not have just cause to discipline her with a three-day suspension issued on March 7, 2016. The State contends just cause supports the discipline.

A closed evidentiary hearing was held on October 25, 2016. Ryan represented herself. Tamara Knight and Kathryn Greenfield represented the State. Ryan delivered her closing argument following the evidentiary hearing and opted not to submit a post-hearing brief. The State submitted its post-hearing brief on November 23, 2016. After considering the evidence and arguments of the parties, I hereby enter the following:

FINDINGS OF FACT

GRC is a state residential facility operated by the Iowa Department of Human Services (DHS) and licensed to care for individuals with intellectual disabilities. The facility currently houses 229 male residents ages 13 to 82 with intellectual disabilities ranging from mild to severe/profound.

Pursuant to GRC's "Single Individual in Charge at All Times" policy, the superintendent, a role currently filled by Gary Anders, is ultimately in charge of the facility. During his absence, an assistant superintendent or a supervisor is designated as the administrator on duty (AOD). For operational purposes, GRC is divided into Area 1 and Area 2 with multiple homes in each area housing GRC residents. The superintendent or the AOD has ultimate responsibility over both areas and has a duty to respond to calls for assistance in either area.

On the GRC hierarchy of responsibility, the "shift supervisor" or "area supervisor" is one step down from the superintendent and the AOD. This individual is responsible for one of the two designated areas and has a duty to respond to calls within the assigned area. The next step down on the hierarchy of responsibility is the resident treatment supervisor (RTS). An RTS works in a regularly assigned house supervising the care provided by resident treatment workers (RTWs) and assists them as needed.

Resident treatment supervisors are assigned the role of "area supervisor" when shift supervisors are off duty. When filling the role of the "area supervisor," the RTS's supervisory duties expand to all the houses in the assigned area, not

just her regularly assigned house. An area supervisor is "directly responsible to the AOD" in taking direction from and responding to the AOD, and contacting the AOD when assistance is needed. An RTS filling the role an area supervisor can also be designated as the AOD for the same shift.

When assigned as an area supervisor, the RTS has a duty to know the required staffing levels in each house within the assigned area, to adequately staff those houses, and to ensure the residents' prescribed levels of supervision are maintained. An area supervisor can mandate RTWs to work longer if she determines it to be necessary to maintain adequate staffing levels. When mandating overtime, however, the supervisor must follow the seniority provisions of the RTWs' collective bargaining agreement. An area supervisor also has a duty to complete rounds to ensure that supervision and care services are being provided consistent with the residents' support plans and to respond to calls for assistance in the area.

Appellant Ryan began her employment with GRC in June 2007 as an RTW. She was promoted to her current position of RTS in October 2009. Ryan is regularly assigned to supervise house 239 (H239) in Area One. She fills the role of an area supervisor on a rotating basis with other supervisors. Since her supervisory promotion in 2009, Ryan is assigned the role of area supervisor approximately every five to six weeks, translating to approximately eight to ten times a year. Ryan's Position Description Questionnaire (PDQ), as updated on February 29, 2016, states that 3% of Ryan's work is to, in part, "Cover the Area

office, pre-schedule overtime, complete area rounds and serve as relief administrator as assigned."

On Sunday, December 27, 2015, Ryan was working her regular second shift, beginning at 1:30 p.m., and was assigned as the Area One supervisor. RTS Dave Millsap was assigned as the Area Two supervisor and also designated as the AOD.

Ryan's assigned Area One consists of nine homes that house approximately 125 to 130 residents. Every house has a set staffing level that is communicated on the supervisor's staffing sheet. Each resident has a prescribed level of supervision that is outlined on the resident's support plan. One of Ryan's duties on December 27 was to ensure the staffing in each of the nine homes in Area One met the set staffing level and that the residents' prescribed level of supervision was being followed.

The December 27 incident underlying Ryan's discipline occurred in H239, her regularly assigned home. On that date, H239 housed a total of 15 clients. Two clients required one-to-one supervision and the remaining 13 were general supervision clients. The "Enhanced Levels of Supervision" policy defines these levels of supervision at GRC. Pertinent sections of the policy state:

> **I. Purpose**
>
> The enhanced supervision protocol is to be followed when supervision is required above the general supervision level due to behavioral/safety reasons. Level 1 is general supervision and levels 2 and 3 are considered enhanced levels of supervision.

II. Definitions of Levels of Supervision from least restrictive to most restrictive.

Level 1: General Supervision: The assigned staff is responsible for providing active treatment per the individual's ISP [Individual Support Plan] and knowing the person's whereabouts at least every 30 minutes.

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Level 3: 1 to 1 Supervision: The assigned staff is responsible for providing active treatment per the individual's ISP and shall have no duties other than the 1 to 1 supervision of the person. Staff's attention shall be directed at the supervision of the person and staff must be able to intervene as needed in less than (#-to be defined by the Interdisciplinary Team) seconds. Any exceptions to this definition will be specified in the BSP [Behavior Support Plan].

GRC's Interdisciplinary Team (IDT) determines the necessary level of supervision for each GRC resident. The resident's prescribed supervision level as contained in his Individual Support Plan (ISP) must be followed by the GRC staff assigned to supervise him.

The primary document that governs GRC operations, including the required staff-to-resident ratios, is the Intermediate Care Facilities for the Intellectually Disabled (ICF/ID) provider manual. Pertinent sections of the manual provide:

Chapter III. Provider-Specific Policies

L. Staff

1. Direct Care Staff

The facility shall provide sufficient direct care staff to manage and supervise residents in accordance with their individual program plans. The facility shall not depend upon residents or volunteers to perform direct care services for the facility.

Direct care staff is defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. There shall be responsible direct care

staff on duty and awake on a 24-hour basis when residents are present to take prompt, appropriate action in cases of injury, illness, fire or other emergency, in each defined residential living unit housing:

- Residents for whom a physician has ordered a medical care plan;
- Residents who are aggressive, assaultive or security risks;
- More than 16 residents; or
- Fewer than 16 residents within a multi-unit building.

There shall be a responsible direct care staff person on duty on a 24-hour basis when residents are present to respond to injuries and symptoms of illness and to handle emergencies in each defined residential living unit housing:

- Residents for whom a physician has not ordered a medical care plan;
- Residents who are not aggressive, assaultive or security risks; and
- 16 or fewer residents.

Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to residents:

- The staff-to-resident ratio is 1 to 3.2 for each defined residential living unit serving:
    - Children under the age of 12,
    - Severely or profoundly intellectually disabled residents,
    - Residents with severe physical disabilities,
    - Residents who are aggressive, assaultive, or security risks, or
    - Residents who manifest severely hyperactive or psychotic-like behavior.
- The staff-to-resident ratio is 1 to 4 for each defined residential living unit serving moderately intellectually disabled residents.
- The staff-to-resident ratio is 1 to 6.4 for each defined residential unit serving residents within the range of mild intellectual disability.

GRC must comply with these ICF/ID staffing ratios to maintain its licensure. Any incident in violation of the ICF/ID regulations must be self-reported to the Iowa Department of Inspections and Appeals (DIA) for investigation. Depending on its findings, the DIA can cite and/or fine the facility for deficiencies, which can place GRC's licensure at risk.

In addition to the required ICF/ID staffing ratios, GRC sets "minimum" staffing levels for each house. For H239, the staffing level is typically six staff on the weekends during the day. The number of staff is reduced to four for the "night watch" shift, which begins between 8:30 p.m. and 9:00 p.m., when the residents are reasonably in bed for the night. The staff working overtime expects to be relieved by 9 p.m. when the staffing is reduced to "night watch" levels. If a staffing need arises, a supervisor has the authority to keep any number of overtime staff until the end of the second shift at 10:15 p.m., but it is not the typical practice in Area 1 to keep overtime staff past 9:00 p.m.

While each house has its set staffing level, including H239, a house can fall below the set or "typical" levels due to call-ins, staff leaving due to illness or emergencies, or when overtime staff is relieved. When this occurs, a house is deemed "short-staffed" and the supervisor is expected to implement a plan to get the house up to its normal staffing level.

On December 27, 2015, nine RTWs were working overtime throughout Area One and all were scheduled to leave at 9:00 p.m. Of the six RTWs in H239, three were working overtime. As such, Ryan knew she had to pull an RTW from a

different house to be in H239 at or before 9:00 p.m. to maintain the typical night watch level of four staff. Sometime around 7:40 p.m., she called RTW Stacey Winchel in H248 and directed her to report to H239 at 9 p.m.

Around the same time, Ryan received a call from RTW John Love in H474 informing her that he had been on duty since 6 a.m. and had not had a break due to an outing in H474 that required staffing during regular break times. Love requested Ryan relieve him for his evening break instead of accepting pay for it. GRC does not schedule "extra" staff to provide break coverage. Instead, breaks are covered by supervisors taking on supervision of clients or shuffling staff around the homes as needed to cover staff breaks. A supervisor taking on supervision of clients to cover a break is "a typical act that may need to occur" during a shift.

In finding break coverage for Love, Ryan concluded this was not an optimal time to pull staff from other homes because other staff breaks, nightly grooming and medication passes were happening in the other homes. Instead, Ryan decided to send an RTW from H239 to H474 to cover Love's break because it would not be as disruptive as pulling staff from other homes. Since H474 is considered "higher risk," she sent RTW Blake Hunt who is "familiar with house 474 men." She signed herself in for Hunt's three general supervision clients in H239 at 7:48 p.m., believing she would only be providing supervision for half an hour while Love took his requested break.

At 7:48 p.m., when Ryan took over supervision of Hunt's three clients, H239 had a total of six staff providing supervision to 15 residents. Two staff were

supervising the two one-to-one clients and four staff were providing general supervision to the remaining 13 clients.

Sometime after 7:48 p.m., while Hunt was still in H474 covering Love's break, Ryan received a call from RTW Shannon Love in H474 requesting relief to take her break. Ryan approved for Hunt to remain an additional half-hour in H474 to also cover Shannon Love's requested break. In making this determination, Ryan correctly calculated that Hunt would still return to H239 prior to 9 p.m., when the overtime staff in H239 was scheduled to leave.

As far as Ryan knew based on her prior directive to Hunt to cover only two half-hour breaks and for Winchel to report to H239 at 9:00 p.m., both Hunt and Winchel should have reported to H239 at or prior to 9:00 p.m. Ryan received no communication from either Hunt or Winchel that her directives would not be followed.

About five minutes or less to 9 p.m., Ryan realized neither Winchel nor Hunt had reported to H239. She recognized this might be an issue since three of the six staff in H239 were scheduled to leave at 9:00 p.m., leaving only her and two other staff to supervise H239 clients. Aware of her ability to mandate overtime staff to stay until 10:15 p.m., Ryan considered this option but concluded that having less than five minutes was not a sufficient amount of time to execute this process. Mandating overtime has to be in accordance with the RTW's collective bargaining agreement provisions that require mandating by seniority. Consequently, Ryan knew she needed seniority dates for all nine staff

working overtime in Area One, either by looking it up or calling each RTW, and then needed to mandate the least senior RTW to stay longer.

Concluding she did not have sufficient time to mandate, Ryan quickly asked the three overtime staff in H239 to volunteer to stay longer until she could get ahold of Winchel and Hunt, but all three declined. Ryan placed a call to the AOD and Area 2 supervisor Millsap to inquire whether he had extra staff and he informed her he did not. Ryan does not recall whether she told Millsap why she needed extra staff. When 9:00 p.m. came, Ryan "felt at the time [she] had no choice but to sign in and then follow up with the staff that had not arrived to get them to house 239 immediately."

Ryan released the overtime staff at 9 p.m. She signed in to supervise the ten general supervision clients previously supervised by the three overtime staff to ensure the residents had supervision while she made phone contact with Hunt and Winchel. In addition, Ryan was still signed in to supervise the three general supervision clients signed over by Hunt when he went to H474 to cover breaks. In total, Ryan was signed in to supervise 13 general supervision clients at 9 p.m. The remaining two clients in H239, the one-to-one supervision clients, continued to receive their prescribed level of supervision from the other two staff in H239.

Ryan immediately made calls to H474 for Hunt and to H248 for Winchel to inquire why they had not shown up to H239.[1] Hunt reported an incident prevented him from coming back to H239 on time, although Ryan does not recall the exact nature of the incident. Winchel reported that she had a conversation with RTW Bob Lidgett in H248, telling him she did not want to be pulled from H248 and for him to go to H239 in her place at 9 p.m. Lidgett presumably agreed but he was not available at the time Ryan called H248. Winchel assured Ryan she would get Lidgett to report to H239. Winchel never notified Ryan of her plan to have Lidgett take her place in H239 until after 9 p.m., when Ryan called to inquire why she had not reported to H239 as directed.

Lidgett arrived to H239 at 9:15 p.m. After completing a required training on enhanced supervision, Lidgett signed in to supervise a one-to-one client at 9:30p.m., who was being supervised by RTW Sharon Ford. Hunt returned to H239 at about 9:40 p.m. and took over supervision of eight clients that Ryan was supervising at 9:42 p.m. Ford took over supervision of Ryan's remaining five clients at 9:56 p.m. [2]

[1] Making phone contact to the house where staff is supposed to be is the standard method of communication when a supervisor is attempting to reach staff even when a supervisor is not signed in to supervise clients. Supervisors are not expected to drive around the facility and physically visit each home within their designated area when attempting to reach staff.

[2] It appears Ford handed over supervision of her one-to-one client to Lidgett at 9:30 p.m. and took over supervision of RTW Mitch Keppard's one-to-one client to allow Keppard to take a break. As such, Ford could not take over supervision of Ryan's clients until Keppard returned from his break.

When providing supervision, staff must follow GRC's "Accountability" policy. Pertinent sections of the accountability policy state:

> I. Standards
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> A. The whereabouts of individuals supported at GRC shall be known by the staff responsible for their care.
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> B. Staff must ensure the accountability of all individuals in residence throughout the day and night and particularly during the cross-over time between staff.
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> II. Implementation
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> A. Staff who is responsible for an individual or a group of individuals must have ongoing knowledge of the individuals' whereabouts.
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> B. The staff responsible must visually see and document on the ACCOUNTABILITY FORM (Form 476-0023) each individual's whereabouts at least every one half-hour.
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> ***
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> J. The Accountability Form shall also document whether a communication exchange between staff occurred at change of shift and whether an environmental walk-through (house or vocational/day program site) was completed.
>
> 1. A verbal and physical communication exchange is required between staff from both shifts at shift change and/or when the staff is going off duty for the remainder of the shift and being replaced by another staff.

During Ryan's supervision of clients from 9p.m. to 9:42p.m. and 9:56p.m., respectively, she was able to provide supervision to all clients in accordance with the Accountability policy. Given that it was their bed time, most clients had gone to their rooms and were easily monitored. Ryan completed all accountability checks and documentation as required by the Accountability policy. No injuries or concerns were reported during Ryan's supervision of clients on December 27, 2015, either in H239 or in any of the other eight homes in Area One.

During the week of January 4, 2016, Treatment Program Administrator Rick Jones participated in a first step grievance meeting involving one of Ryan's subordinates, RTW MK, who received a written reprimand for neglect when he failed to follow a client's prescribed level of supervision as outlined in the client's behavior support plan. Ryan was the reporter in MK's neglect incident. During MK's grievance meeting, his union steward stated Ryan was signed in to supervise 13 clients in H239 on December 27, 2015, and alleged that her actions were in violation of the Accountability policy. The union steward cited Ryan's lack of discipline as an example that the same disciplinary standards are not applied to all staff at GRC.

On January 7, 2016, Jones asked Ryan's direct supervisor, Treatment Program Manager Kate Kingery, whether she was aware that Ryan was signed in to supervise 13 clients for a period of time on December 27, 2015. Kingery reported she was not aware of it. Later that day, Kingery asked Ryan about the incident. Ryan confirmed it and Kingery expressed concern to Ryan that supervising 13 clients as an area supervisor is "excessive and a concern" and that better planning would have been better.

On January 11, 2016, Jones reported the incident to Katherine Rall, who in turn assigned the incident for investigation to investigator Kimberly O'Connor.[3] GRC "felt responsible to complete an investigation to determine if indeed [the] allegations were correct." The investigation consisted of reviewing all applicable

[3] It is unclear who Rall is as the record only describes her position as "DQM."

policies and work rules, the accountability sheets for December 27, 2015, and an interview with Kingery and Ryan.

On January 12, 2016, Kingery was interviewed and signed a witness statement as part of the investigation. Kingery confirmed she spoke to Ryan on January 7, 2016, and "expressed concern w/Amy about the coverage given she had the office," referring to Ryan's duties as the area supervisor. Kingery "recognized [Ryan's] intent was to help but taking 13 accountabilities when she is the area RTS is excessive and a concern." Kingery noted she expects Ryan "to help cover clients as needed throughout the day – usually it's a group around 4-5 people" but further stated that as the area supervisor, Ryan "shouldn't cover any groups because she [can't] just leave." Kingery did not recall training Ryan on "accountabilities/protocols" and is not aware of Ryan's previous training on "accountabilities/breaks." Kingery also stated that recent supervisor meetings have placed greater emphasis on reducing overtime hours and that the practice has been to allow overtime staff to leave at 9 p.m.

By January 14, 2016, after reviewing the accountability sheets for December 27, 2015, GRC determined the incident did not violate ICF/ID required staffing ratios, and therefore, the incident did not require self-reporting to DIA.

On January 19, 2016, Ryan was interviewed and submitted a witness statement as part of the investigation. She acknowledged her duties as the area supervisor were "to set the shift, complete rounds in each house to ensure direct care/active treatment was being provided as well as addressing any issues that

might arise." Ryan explained the string of events that occurred and the reasoning behind her staffing decisions on December 27, 2015. Those facts are as previously articulated.

Ryan confirmed that she eventually signed in to supervise 13 clients at 9:00 p.m., after releasing the overtime staff and the two staff members had failed to report to H239 by 9:00 p.m. as she previously directed. During the investigatory interview, Ryan told the investigator she made contact with AOD Millsap asking for extra staff but that she does not recall whether she explained the situation to him, adding that Millsap "might be able to tell [the investigator] more of that."

The investigation found that "a group this size [13] is often covered by 1 person on [night watch] shift, at least for periods of time." It also found that Ryan had her phone and radio with her the entire shift, allowing her immediate contact with the AOD if his assistance was needed. During the investigatory interview, Ryan stated she had previously encountered similar situations of not having adequate staff to shuffle around when overtime was scheduled to leave but those situations were "not to this degree." She was able to manage those previous situations without any problems. Ryan recognized the situation of supervising 13 clients was not ideal but all her other resources were exhausted. She believed her decisions to be in line with GRC policies and common practice.

The investigator sent her investigative summary to Rall on January 27, 2016, and it appears GRC reached its investigative conclusion on February 22, 2016. The investigation "substantiated" that Ryan was signed in to supervise 13

general supervision clients from 9:00 to 9:42 p.m. while serving as the Area One supervisor. This finding "was of significant concern to the administration." Superintendent Anders concluded discipline was warranted because Ryan made a "poor decision" that placed the facility and the residents at risk in the event action needed to be taken.

On March 7, 2016, Ryan was given a notice of discipline advising her that the investigation concluded she violated several DHS work rules. The letter stated, in pertinent part:

> This is to advise you that the investigation into your alleged violations of the department work rules and state policies is concluded. Because of the infractions, you are hereby subject to this written notice of alternative discipline in lieu of a suspension without pay. While this action does not reduce your pay, seniority, or other benefits, it does carry the same weight as if you had been subject to a **3-day suspension**. It is imperative that you understand that your failure to follow the department's work rules and policies is a serious matter and monitoring of your conduct will continue. Any further violation of DHS policies or work rules will result in more severe disciplinary action being taken, up to and including discharge.
>
> The investigation concluded that on December 27, 2015, you exercised poor judgment while working as the Area One Officer Supervisor. On that evening, you failed to direct house staffing to insure proper ratios were maintained in 239; failed to insure your availability to respond to needs within the Area; and, failed to communicate with the AOD regarding your status and availability.
>
> Due to your actions, you are in violation of the following DHS work rules:
>
> Section D-1 General Standards of Conduct and Work Rules
> The following general standards of conduct and work rules are intended to illustrate minimum expectations for acceptable work performance and workplace behavior. They are not all-inclusive. Misconduct not specifically described will be handled as warranted by

> the circumstances of the case involved. Violation of a work rule may result in discipline up to and including discharge, and in some cases may result in legal action.
>
> D-1(1) An employee's job is important, and employees are expected to cooperate and follow the instructions of supervisors or other designated members of management. Insubordination (intentional refusal to follow an authorized supervisor's reasonable orders or instructions) is prohibited unless such instructions are contrary to the Code of Iowa.
>
> D-1(2) Poor work is not acceptable. Employees are expected to perform their work properly and efficiently and to meet performance standards. Employees are expected to seek, accept and accurately complete assignments within deadlines and not neglect job duties and responsibilities.
>
> It is imperative that you recognize your role as a supervisor to plan and anticipate potential problems and concerns so that you can respond quickly and effectively. During this incident you failed to insure your ability to respond appropriately to the needs of the area.

Ryan acknowledged receiving the notice of discipline on the same day.

In determining the appropriate level of discipline, Anders took into account Ryan's previous discipline and overall performance as an employee. Ryan previously received a "work directive regarding job performance" essentially directing her to do the following: "For all incidents where client neglect/abuse is suspected, you will immediately separate and report. You will ensure an IAR is completed and nursing is notified." The work directive is dated September 6, 2014, but Ryan did not receive a copy of it until October 8, 2014.

On October 1, 2014, Ryan received a three-day suspension for failing to adequately perform her supervisory duties as directed by the work directive,

referenced above, which she appears to have received after the October 1 discipline. The notice of discipline stated, in part:

> Specifically: On 9/13/14, you observed an RTW not following the supervision requirements for a person we serve who requires 1:1 supervision and failed to follow facility procedures for this incident. The RTW should have been separated immediately, an incident report should have been filled out, nurse notified and the incident reported to the Administrator on Duty immediately.

Ryan's inaction on September 13, 2014, was determined to be in violation of DHS work rule D-1(1) and D-1(2), the same work rules that are alleged to have been violated in the current three-day suspension on appeal. The investigation pertaining to the current three-day suspension conclusively determined that no neglect/abuse occurred on December 27, 2015. However, even absent any factual similarities between the two incidents, Anders concluded that since both incidents were found to violate the same DHS work rules, it was appropriate to consider Ryan's previous three-day suspension in determining the level of discipline for the December 27 incident.

Ryan's two most recent performance evaluations were also reviewed in determining the level of discipline to impose. The evaluation period covering September 8, 2013 through September 7, 2014 received an overall "meets expectations" rating. On two of her six individual performance goals, Ryan received a "does not meet expectations" rating. One of these unsatisfactory ratings pertained to fostering positive working relationships that were apparently strained

because of a difference in opinion over resident treatment decisions. The second goal that did not meet expectations was the following:

> 4. Work Quality/Quantity: Completes tasks/projects in a timely manner, without prompting. Work is thorough, lacking in errors and does not have to be redone. Continuously reviews own work to ensure quality and achievement of expectations. Completes work according to rules, laws, procedures, standards, etc., applicable to the job.

Her supervisor's feedback stated:

> Amy is very rule governed and makes effort to complete her job duties timely and per standards. At times, however, there are decisions that need made which do not have guidelines of a policy/protocol behind them and common sense or understanding of best practice is needed and should be used. Here is where working with the team can help accomplish goals when guidelines are unclear. Amy had an incident this past performance period where she failed to follow procedures when witnessing an inappropriate interaction between a staff and a person we serve (failed to separate immediately).

The second performance evaluation reviewed covers the period of September 8, 2014 through September 8, 2015. The performance plan for that period, which should have been discussed with Ryan in September 2014, was not given to her until February 29, 2016, the same day she received her completed evaluation and ratings for that period. Ryan received an overall "meet expectations" rating. The two performance goals for which she previously received "does not meet expectations" during the previous rating period improved to "meets expectations." On the "work quality/quantity" goal that improved to "meet expectations," Ryan's supervisor noted Ryan's "organization and ability to meet deadlines are superb."

On the "teamwork" performance goal that improved to "meets expectations" for this evaluation period, the supervisor stated:

> Amy works with her peers to cover the area office and has taken a leadership role in scheduling and discussing the staffing at supervisory meetings. Amy volunteers to help cover interviews and avoids volunteering on days where the unit needs her assistance. When covering one PM office, Amy failed to recognize possible consequences of her decision to staff and cover the area.

The December 27, 2015 incident underlying the instant discipline on appeal technically occurred outside of the evaluation period for this performance evaluation; however, the reference to Ryan "fail[ing] to recognize possible consequences" appears to refer to the December 27 incident.[4] Even with the December 27 incident known and referenced by her supervisor and performance evaluator, Ryan still received a "meets expectations" for this goal that requires her, in part, to "complete[] work according to rules, laws, procedures, standards, etc., applicable to the job."

Ryan's supervisor also provided her with additional guidance on performance, such as instructing her that, "As a supervisor in an ever changing environment, at times you'll have only seconds to weigh all your options and make a decision. Work on those skills so you're able to make good decisions swiftly and courteously." She also set a "development plan" for Ryan that stated:

> Practice self reflection as a means to improve job performance. Try to see problems as opportunities to learn. Amy needs to look for opportunities to act decisively and seek feedback from her

[4] This performance evaluation was completed in February 2016, after the December 27 incident was known and investigated by GRC. Ryan's notice of discipline for the incident was issued a week after the performance evaluation was given to her.

> supervisor afterward. She would benefit from understanding that although her response to a situation may not be perfect, the timing and effort are often just as important. She needs to recognize that asserting her leadership will become easier with time and help her to be successful. She should talk to her supervisor(s) to process and develop more comfort and confidence with addressing issues.

Anders decided not to build on Ryan's previous discipline. Instead, he decided to repeat a three-day suspension after considering and balancing the fact that the "previous discipline was for a violation of the same work rules as this discipline" against "the time period where Ms. Ryan had demonstrated some success in her position" following her prior discipline. Anders also considered Ryan's "admission" to the incident when deciding not to impose a more severe level of discipline.

On March 8, 2016, Ryan filed a step three appeal of disciplinary action with DAS pursuant to Iowa Code section 8A.415(2)(*a*) and DAS rule 11—61.2(6) claiming the "discipline was unwarranted due to no policies or protocols violated as well as improper training regarding expectations" and that the "discipline was also untimely."

A third step meeting was held on April 5, 2016. Ryan argued that she spoke to 12 other supervisors who confirmed it was "common practice and a recognized responsibility to relieve breaks when staffing is short or at minimum staffing numbers." She also indicated that she spoke to the after-hours administrators (AODs) and they both indicated they do not require notification unless a supervisor is in need of assistance.

Following the third step grievance meeting, the DAS director's designee denied Ryan's grievance on April 13, 2016, concluding the discipline was warranted and supported by just cause. Ryan then filed the present appeal on April 18, 2016.

CONCLUSIONS OF LAW

Ryan filed this appeal pursuant to Iowa Code section 8A.415(2), which states:

> 2. *Discipline Resolution*
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> a. A merit system employee … who is discharged, suspended, demoted, or otherwise receives a reduction in pay, except during the employee's probationary period, may bypass steps one and two of the grievance procedure and appeal the disciplinary action to the director within seven calendar days following the effective date of the action. The director shall respond within thirty calendar days following receipt of the appeal.
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> b. If not satisfied, the employee may, within thirty calendar days following the director's response, file an appeal with the public employment relations board … If the public employment relations board finds that the action taken by the appointing authority was for political, religious, racial, national origin, sex, age, or other reasons not constituting just cause, the employee may be reinstated without loss of pay or benefits for the elapsed period, or the public employment relations board may provide other appropriate remedies.

The following DAS rules set forth specific discipline measures and procedures for disciplining employees.

> **11—60.2(8A) Disciplinary actions.** Except as otherwise provided, in addition to less severe progressive discipline measures, any employee is subject to any of the following disciplinary actions when the action is based on a standard of just cause: suspension, reduction of pay within the same pay grade, disciplinary demotion, or discharge… Disciplinary action shall be based on any of the following reasons: inefficiency, insubordination, less than competent job performance, refusal of a reassignment, failure to perform assigned duties, inadequacy in the

> performance of assigned duties, dishonesty, improper use of leave, unrehabilitated substance abuse, negligence, conduct which adversely affects the employee's job performance or the agency of employment, conviction of a crime involving moral turpitude, conduct unbecoming a public employee, misconduct, or any other just cause.
>
> **60.2(1)** Suspension.
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> ***
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> *b. Disciplinary suspension.* An appointing authority may suspend an employee for a length of time considered appropriate not to exceed 30 calendar days … A written statement of the reasons for the suspension and its duration shall be sent to the employee within 24 hours after the effective date of the action.

The State bears the burden of establishing that just cause supports the discipline imposed. *See, e.g.*, *Phillips and State of Iowa (Department of Human Resources)*, 12-MA-05. The term "just cause" as employed in section 8A.415(2) and administrative rule is not defined by statute or rule. *Stockbridge and State of Iowa (Department of Corrections)*, 06-MA-06 at 21. Determination of whether management has just cause to discipline an employee is made on a case-by-case basis. *Id.* at 20.

In determining whether just cause exists, PERB examines the totality of circumstances in each case. *See, e.g.*, *Cooper and State of Iowa (Department of Human Rights)*, 97-MA-12 at 29. As previously stated by the Board,

> [W]e believe that a § 19A.14(2)[now § 8A.415(2)(b)] just cause determination requires an analysis of all the relevant circumstances concerning the conduct which precipitated the disciplinary action, and need not depend upon a mechanical, inflexible application of fixed "elements" which may or may not have any real applicability to the case under consideration.

Hunsaker and State of Iowa (Department of Employment Services), 90-MA-13 at 40. While emphasizing there is no "fixed test" to determine the presence or absence of just cause, the Board has instructed that an analysis of the following factors may be relevant:

> While there is no fixed test to be applied, examples of some of the types of factors which may be relevant to a just cause determination, depending on the circumstances, include, but are not limited to: whether the employee has been given forewarning or has knowledge of the employer's rules and expected conduct; whether a sufficient and fair investigation was conducted by the employer; whether reasons for the discipline were adequately communicated to the employee; whether sufficient evidence or proof of the employee's guilt of the offense is established; whether progressive discipline was followed, or not applicable under the circumstances; whether the punishment imposed is proportionate to the offense; whether the employee's employment record, including years of service, performance, and disciplinary record, have been given due consideration; and whether there are other mitigating circumstances which would justify a lesser penalty.

Hoffmann and State of Iowa (Department of Transportation), 93-MA-21 at 22. Another factor that has been deemed relevant by the Board is how other similarly situated employees have been treated. *Kuhn and State of Iowa (Commission of Veterans Affairs)*, 04-MA-04 at 42.

PERB has consistently held that the presence or absence of just cause must rest solely on the reasons stated in the disciplinary letter. *Eaves and State of Iowa (Department of Corrections)*, 03-MA-04 at 14. This requirement is derived from Iowa Code section 8A.413(18)(*b*), which states "[t]he person discharged, suspended, or reduced shall be given a written statement of the reasons for the discharge, suspension, or reduction within twenty-four hours after the

discharge, suspension, or reduction." In accordance with this statutory directive and DAS rule 11—60.2(1), quoted *supra*, PERB has consistently found that the disciplinary notice must contain the reasons for the disciplinary discharge, suspension or demotion, and that just cause must be determined solely upon the reasons stated in the notice of discipline. *See, e.g.*, *Hunsaker and State of Iowa (Department of Employment Services)*, 90-MA-13 at 46, n. 27.

Ryan was disciplined for exercising "poor judgment" as the Area One supervisor on December 27, 2015 because she (1) failed to direct house staffing to insure proper ratios were maintained in H239; (2) failed to insure her availability to respond to needs within the Area; and (3) failed to communicate with the AOD regarding her status and availability.

The investigation included a review of all applicable policies and work rules, including policies specifically pertaining to staffing ratios and accountability requirements. The notice of discipline, however, does not rely on her violation of any of these specific policies but relies on two work rules of general applicability. It alleges Ryan's three "failures" violate DHS General Standards of Conduct and Work Rules section D-1(1), which generally states that employees are expected to follow the instructions of supervisors and prohibits insubordination, and D-1(2), which generally prohibits "poor work" and the "neglect [of] job duties and responsibilities."

For the reasons explained below, I conclude the three-day suspension issued to Ryan is not supported by just cause.

(1) Failed to direct house staffing to insure proper ratios were maintained in H239

To understand this purported failure, it is important to distinguish the different staffing ratios referred to by the parties, such as the ICF/ID "required ratios" and house "minimum ratios" as set by GRC.[5] Ryan's notice of discipline refers to "proper ratios."

Required ratios, as set by the ICF/ID provider manual, dictate the minimum staff-to-client ratios which must be maintained on a 24-hour basis to avoid neglect/abuse findings by the DIA. Falling below these required ratios would subject GRC to investigation, fines and/or loss of licensure.

Ryan's decision to sign in to supervise 13 clients on December 27, 2015, kept GRC within the ICF/ID required staffing ratios. As such, DIA was not notified and had no involvement with the investigation of this incident. The State does not dispute either one of these facts.[6] Consequently, to the extent the reference to "proper ratios" in the notice of discipline is referring to the required ICF/ID staffing ratios, it is not accurate because those required ratios were maintained.

[5] "Minimum" house ratios or staffing levels are also referred to by the parties as "typical," "normal" and "recommended" ratios.

[6] During the investigation, correspondence indicates a question was raised whether a supervisor can count as direct care staff in calculating the 24 hour coverage ratio under the ICF/ID regulations. The investigator concluded Ryan falls under the exception that a supervisor counts as direct care staff if she is regularly assigned to provide support duties during the normal course of the day. It does not appear the State is arguing Ryan could not count as direct care staff and that is why the house was not adequately staffed. However, to the extent this is still an issue that needs to be addressed, I find the record supports a finding that Ryan does fall within the exception as her supervisor stated Ryan is expected to and regularly provides support duties.

At the facility level, GRC sets its own "minimum" staffing level for each house and those are noted on the supervisor's staffing sheet. An area supervisor is expected to know and assign staff to meet the set house staffing level. Ryan readily acknowledges that from 9:00 p.m. to 9:42 p.m., H239 only had three staff supervising clients, which is one below set staffing level of four staff in H239. Consequently, to the extent "proper ratios" in Ryan's notice of discipline can reasonably be interpreted to be referring to the set staffing level for H239, I conclude Ryan failed to maintain the typical staffing level of four staff in H239 for 42 minutes.

An important consideration when determining the existence or absence of just cause is whether the employer provided the employee with notice of the possible or probable consequences resulting from specific conduct. In this situation, the State has not demonstrated that Ryan was given forewarning or foreknowledge that running a house below the set house staffing level under these circumstances would subject her to discipline. When the record shows, as it does here, that minimum staffing levels are deviated from based on the needs at the time (*e.g.*, employee call-ins, providing break coverage or relieving overtime) with no disciplinary consequences, it cannot also support a finding that Ryan knew falling below the set house staffing level this time would subject her to discipline.

Even though Ryan failed to maintain the "minimum" staffing level in H239 for 42 minutes, that finding is not the end of the just cause analysis. The record

also supports a finding that previous deviations from the "minimum" staffing levels, under circumstances identical to this situation, have not resulted in employee discipline. Falling below the house minimums, *i.e.* "short staffing," regularly occurs due to call-ins, employee emergencies, overtime relief, or the needs of other homes, such as providing break coverage. The house staffing levels are fluid and regularly change based on need; thus, the supervisor on duty is expected to shuffle staff around and cover as needed. There is nothing in the record which shows that a supervisor has ever been disciplined for running a house below the "minimum" staffing level. Anders conceded to knowing of other "occasions when short staffing does occur" and gave no indication that the supervisor on those occasions received any discipline for having a house fall below the set house staffing level.

Anders added that when short staffing occurs during a shift, he expects a supervisor to implement a plan to get the staffing up to its normal or typical level. I conclude Ryan met this expectation as well. Prior to 9:00 p.m., Ryan appropriately directed staff to ensure the set house staffing levels were maintained when overtime left at 9:00 p.m. The two staff she counted on failed to report to H239 as directed. As soon as overtime left and H239 reduced to three staff, Ryan made contact with the two RTWs who failed to show up. She confirmed they would be on their way to H239. Ryan took action for implementing supervision as needed when H239 became "short-staffed."

The record further demonstrates that Ryan's supervision of 13 clients did not violate the "Accountability" policy or the "Enhanced Levels of Supervision" policy. She was able to complete all the required checks and documentation consistent with the clients' prescribed levels of supervision. The number of clients Ryan supervised was an acceptable practice at GRC. The investigation determined that a group of 13 general supervision clients, such as the group Ryan was supervising, "is often covered by 1 person on [night watch] shift, at least for periods of time." Anders admitted that a staff member's supervision of 13 clients "would not be unheard of for a short amount of time." Ryan's supervision of 13 clients lasted for 42 minutes of an almost nine-hour shift, which I find to be "a short amount of time."

Under the entirety of the record, I conclude Ryan did not have foreknowledge or forewarning that falling below the "minimum" house staffing level under the circumstances as presented on December 27, 2015, would subject her to discipline. As such, Ryan was not provided with notice that falling below the set house ratios would be considered insubordination under D-1(1) or a neglect of job duties and responsibilities under D-1(2). I thus conclude no just cause has been established based on the failure to ensure "proper ratios."

(2) Failed to insure her availability to respond to needs within Area One

Ryan does not dispute that she had a duty as the area supervisor to respond to the needs of Area One homes. She contends she met the needs in Area One. The investigation concluded that during the time Ryan was

supervising clients in H239, no other requests for her assistance were made. As such, the evidence shows not one need went unanswered or unaddressed by Ryan during the time she was supervising clients.

The State argues, however, that her duty as the area supervisor is broader. The duty extends to being available to respond to any needs within her area, not just responding to needs as they are reported. The State appears to portray this as the expectation regardless of the duration or the reason for a supervisor's unavailability. Consequently, the fact that no other incident requiring her attention occurred is just "lucky" and has no bearing on Ryan's failure to meet her duty to be available to respond to the needs in Area One.

The State can certainly argue the expectation is that broad, but much like with the analysis under section (1) above pertaining to house staffing levels, the State must demonstrate that Ryan had notice of this broad expectation. Specifically, the State must show Ryan had foreknowledge or forewarning that "unavailability" for any reason or amount of time while serving as the area supervisor would subject her to discipline. The State has not shown Ryan had such notice.

First, the expectation to be "available" as broadly defined by the State is not included in any of the written policies or work rules as they articulate no specific expectation for area supervisors to be "available" at all times. Ryan's PDQ also does not support the State's broad interpretation of this duty. The only expectation in her PDQ pertaining to this is that 3% of the time, Ryan is to

"cover the Area office, pre-schedule overtime, complete area rounds and serve as relief administrator as assigned."

Next, there is no evidence that Kingery, Ryan's immediate supervisor, trained or notified her of the expectation that Ryan must be available at all times. Kingery expects Ryan to cover clients as needed during a shift. During the investigation of the December 27 incident, Kingery told the investigator that as the area supervisor Ryan "shouldn't cover any groups" because it may impact her ability to leave when needed. However, there is no evidence that Kingery ever communicated this expectation to Ryan prior to the December 27 incident.

Finally, the expectation as expansively interpreted by the State, is in conflict with the supervisor's duty to actually respond to the needs within an area. A supervisor attending to any one need at a given time will make her "unavailable" to respond to a different need, at least for a period of time. Under the State's interpretation of availability to respond, an area supervisor would be subject to discipline for responding to any need because the supervisor would then be unavailable to respond to other needs.

Even events that occurred earlier in the evening on December 27 are in conflict with the State's interpretation of the area supervisor's duty to be available to respond. Ryan signed in at 7:48 p.m. to supervise three general supervision clients in order to provide requested break relief. Pursuant to the Accountability policy, Ryan is considered the staff responsible for conducting

and documenting the required checks for these three clients. Practically speaking, Ryan was unavailable to respond to a different need at the same time.

The State, however, finds no issue with this earlier supervision of clients, arguing that the earlier situation is different because other staff in H239 were available to take over supervision in case Ryan was needed elsewhere. This is true, but the distinction highlights no meaningful difference when talking about being available as the expectation. If Ryan had received another call for assistance at 8:00 p.m., she still would have had to take time to designate a replacement, sign herself out and see that the replacement took over supervision in order to make herself "available" to respond to that need. Regardless of whether a request for assistance had come in before or after 9:00 p.m, Ryan would still have had to take some form of action prior to responding to the second need, either by reassigning supervision to other staff or contacting the AOD to address the second need.

I can certainly agree that a supervisor's unavailability to respond, under certain circumstances, might constitute insubordination under D-1(1) or a neglect of job duties and responsibilities under work rule D-1(2). For example, a supervisor being unavailable because she is attending to a personal task during work hours could be considered a neglect of job duties and responsibilities. But that scenario is far from the facts of this case. Regardless of DHS' characterization of Ryan's decision to sign in to supervise 13 clients as "poor decision-making," the fact of the matter is that her decision was in response to a

need to provide these 13 residents with supervision when the overtime staff left and the two staff failed to report to H239 at 9:00 p.m. She was "unavailable" because she was fulfilling her duties as the supervisor to step in when she was needed.

Under the record presented here, the State failed to establish that Ryan had foreknowledge or forewarning that being "unavailable," when unavailability was caused by attending to a need in the area to provide supervision, would subject her to discipline. Consequently, Ryan did not have notice that her "unavailability" as caused by the circumstances of December 27 would be considered insubordination under D-1(1) or a neglect of job duties and responsibilities under D-1(2). I thus conclude no just cause has been established based on the failure to be "available" to respond.

(3) Failed to communicate with the AOD regarding her status and availability

A dispute exists between the parties whether Ryan had a duty to notify the AOD regarding her "status and availability" while she was signed in to supervise 13 clients. While there are no written rules or directives in the record which specifically inform supervisors of this expectation, Anders contends it is reasonable to expect any employee who is "not available to respond" or "not able to complete" her duties, to contact her supervisor. Ryan, on the other hand, agrees a duty to contact the AOD exists but only when a supervisor actually needs assistance. Ryan argues she was attending to the needs in the area during

the time she was signed in to supervise clients and the AOD's assistance was not needed.

Even though this disagreement exists regarding required notifications and their applicability here, it is unnecessary to resolve it. Even if one accepts the State's view of this expectation, the State has not established that Ryan failed to inform the AOD of her "status and availability."

The record demonstrates Ryan talked with the AOD on December 27 about extra staff but does not reveal whether or not she explained the specifics of her situation. Ryan has consistently maintained that she does not recall. She once reasoned during the investigatory interview that if she cannot remember explaining the situation perhaps she did not do it, but later reiterated in the same interview that she did not recall whether she told him about the situation. The limited evidence in the record does not warrant a finding that Ryan in fact failed to inform the AOD of her "status and availability."

Based on the entirety of the record, I find the State has failed to establish that Ryan failed to notify the AOD of her "status and availability." As such, even assuming the expectation is as portrayed by the State, the evidence does not demonstrate she failed to meet it in violation of D-1(1) or D-1(2).

For the foregoing reasons, the State did not demonstrate that the three-day suspension issued to Ryan is supported by just cause.

Accordingly, I hereby propose the following:

ORDER

Amy Ryan's state employee disciplinary action appeal from the three-day suspension is hereby GRANTED. The State shall rescind the discipline and make appropriate adjustments to her personnel file.

DATED at Des Moines, Iowa this 20th day of January, 2017.

/s/ Jasmina Sarajlija
Administrative Law Judge