COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2011-269

CHARLENE ELSTON **APPELLANT**

VS.

FINAL ORDER
SUSTAINING HEARING OFFICER'S
FINDINGS OF FACT, CONCLUSIONS OF LAW
AND RECOMMENDED ORDER

JUSTICE AND PUBLIC SAFETY CABINET
DEPARTMENT OF JUVENILE JUSTICE
J. MICHAEL BROWN, APPOINTING AUTHORITY **APPELLEE**

** ** ** ** **

The Board at its regular March 2013 meeting having considered the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer dated January 8, 2013, and being duly advised,

IT IS HEREBY ORDERED that the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer be, and they hereby are approved, adopted and incorporated herein by reference as a part of this Order, and the Appellant's appeal is therefore **DISMISSED**.

The parties shall take notice that this Order may be appealed to the Franklin Circuit Court in accordance with KRS 13B.140 and KRS 18A.100.

SO ORDERED this _____ day of March, 2013.

KENTUCKY PERSONNEL BOARD

_____
MARK A. SIPEK, SECRETARY

A copy hereof this day sent to:

Hon. Jamhal Woolridge
Hon. Brenda Dinkins Allen
Joslyn Glover

COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2011-269

CHARLENE ELSTON **APPELLANT**

VS. **FINDINGS OF FACT, CONCLUSION OF LAW AND RECOMMENDED ORDER**

JUSTICE AND PUBLIC SAFETY CABINET
DEPARTMENT OF JUVENILE JUSTICE
J. MICHAEL BROWN, APPOINTING AUTHORITY **APPELLEE**

** ** ** ** **

This matter came on for evidentiary hearing on August 20, 2012, at 9:30 a.m., at 28 Fountain Place, Frankfort, Kentucky, before Geoffrey B. Greenawalt, Hearing Officer. The proceedings were recorded by audio/video equipment and were authorized by virtue of KRS Chapter 18A.

The Appellant, Charlene Elston, was present at the evidentiary hearing and was represented by the Hon. Brenda Dinkins Allen. The Appellee, Justice and Public Safety Cabinet, Department of Juvenile Justice, was present and was represented by the Hon. Jamhal Woolridge.

The issue at the evidentiary hearing was the Appellant's three-day suspension without pay. The burden of proof was upon the Appellee to demonstrate by a preponderance of the evidence that the disciplinary action taken against Appellant was neither excessive nor erroneous and was taken with just cause.

BACKGROUND

1. The Appellant, Charlene Elston, timely filed her appeal with the Personnel Board on December 8, 2011, appealing from her three-day suspension from duty and pay for poor work performance as a Nurse Shift Program Supervisor, at Audubon Youth Development Center (AYDC).

2. The first to testify was **Ms. Louise Inman**. Ms. Inman serves as a Nurse Service Administrator for the Department of Juvenile Justice (DJJ). Her duties entail supervising the clinical care of the children in the Department's custody. Ms. Inman hired the Appellant and knows the Appellant and states that the Appellant has sole responsibility for the operation of her department.

3. On October 14, 2011. Ms. Inman was filling in for the Agency nurse who typically works at the Westport Group Home one day per week for four hours. The Agency nurse in this instance was on maternity leave.

4. The Westport Group Home and the AYDC handle youths who have committed adult crimes and who have behavioral problems. Ms. Inman explained that whenever youths are transferred to different facilities, their medical file/chart goes with them.

5. According to Ms. Inman, a youth, referred to herein as "PD," had recently transferred from AYDC to the Westport Group home when she came upon his medical file. According to Ms. Inman, his file was falling apart and contained loose documents. Also, the Discharge Summary found in PD's file, which is a brief summary of a youth's medical history, was practically blank. Ms. Inman talked to the staff at the Westport facility and they had no idea why the file was in that shape. Looking into it further, Ms. Inman called over to the AYDC and spoke with the Appellant. The Appellant told Ms. Inman she was wondering where PD's chart had gone. According to Ms. Inman the Appellant stated that she assumed the file had gone with PD to the Westport facility.

6. Ms. Inman was upset that the file and the Discharge Summary came over in such an incomplete state. According to Ms. Inman, the Agency nurse at the Westport facility only works there four hours per week and needs a good Discharge Summary so she can get a brief, quick and accurate understanding of a youth's current medical situation.

7. Appellee's Exhibit 1 was introduced through the witness and is a copy of PD's Discharge Summary Ms. Inman first found in his file. She stated that this was supposed to be attached to the front of the file and noted that very little information had been filled out. She also noted that the summary indicated there were "no known allergies" for PD. Ms. Inman stated that fully and accurately completing the summary was critical in order to maintain continuity of care for youths that are transferred from one facility to another.

8. Because of the lack of information contained on PD's discharge summary, Ms. Inman went through his entire file and filled it in the best she could. She also interviewed PD who told her cinnamon caused his throat to become itchy and close up. Within PD's file, Ms. Inman found that the Appellant had been informed of PD's reaction to cinnamon causing her to send a note to the kitchen staff at AYDC. Appellee's Exhibit 2 was introduced through the witness and is a copy of the Appellant's instructions to the kitchen staff regarding PD's cinnamon allergy. However, this allergy was not noted on the Discharge Summary.

9. Ms. Inman was concerned enough about the failure to include PD's cinnamon allergy on his discharge summary that she called Dr. Sheridan, the Medical Director, and reported the same. She then shared her concerns with the Appellant.

10. Appellee's Exhibit 3 was introduced through the witness and is a copy of what is known as the Declination Form. This form is supposed to be filled out each time a youth declines to take his medicine. It demonstrates further for the file that the child was offered his medications each day. According to Ms. Inman, it is hoped that over time a nurse or staff member can build a rapport with the child and eventually talk him or her into taking his medications. According to Ms. Inman, this form is written proof of care and that "if it is not written then it was not done." Appellee's Exhibit 4 was introduced through the witness and is the Medication Administration Record for PD for October, 2011. Appellee's Exhibit 5 was introduced through the witness and is a copy of the Physician's Orders sheet for PD. This order sheet demonstrates that PD was to be given Abilify just before bedtime. However, a review of Appellee's Exhibit 4 demonstrates that contrary to doctor's orders, the Abilify was being given to the child at 7:00 a.m. in the morning.

11. Appellee's Exhibit 6 was introduced through the witness and is PD's Medication Administration Record for September, 2011. What caught Ms. Inman's attention was that PD refused the medications so they were stopped on September 8, 2011. According to Ms. Inman, the only way to stop a youth's medication is by a doctor's order and no such order, oral or otherwise, was noted in the file.

12. Appellee's Exhibit 7 was introduced through the witness and is a copy of the e-mail Ms. Inman sent to Kristie Stutler, with copies to Dr. Sheridan and Ms. Deborah Curry, regarding the Appellant. This e-mail speaks for itself and sets forth Ms. Inman's concerns regarding PD's file including when his medications were being given, and that his allergy to cinnamon was not properly noted. According to Ms. Inman, this was just another example of poor work performance by Ms. Elston as a supervisor at Audubon.

13. According to Ms. Inman, she and others had a meeting with the Appellant regarding these concerns. At that time, the Appellant admitted she changed the time PD's medications were given because PD would not take his medications at bedtime because he believed they kept him awake. As such, she decided to simply give him the medications in the morning. The Appellant also told Ms. Inman that she called the doctor later regarding this change, but Ms. Inman stated she could find no notation in PD's file indicating that had occurred.

14. Regarding the failure to continually fill out the medication Declination Form, the Appellant said she documented the Declination one time and thought that was enough. Ms. Inman informed the Appellant she was supposed to continue to offer the child his medications and document each time that he declined. In response, the Appellant just shrugged her shoulders.

15. The Appellant also admitted that PD told her he was allergic to cinnamon which caused her to talk to the kitchen staff about it. (See Appellees Exhibit 2). The kitchen staff told the Appellant PD had already eaten quite a bit of food with cinnamon in it since coming to AYDC and noted there had been no reaction to the same. Ms. Inman was of the opinion they had simply been lucky and the allergy should have been noted on PD's Discharge Summary. In response, the Appellant stated the discharge summary was incomplete because PD's chart had disappeared on them before they had the opportunity to completely fill it out. This was allowed to occur because Nurse Jent failed to properly secured the file per agency policy. Instead, upon being called away on an urgent matter while filling the discharge summary out, Nurse Jent left the file behind one locked door (that several other staff members had a key to) rather than being locked up in a place where only authorized personnel could get to it. Appellant's Exhibit 1 was introduced to the record and is the Appellant's response to having PD's chart out in the open. According to Ms. Inman, the Appellant stated that since PD was transferred to the Westport Group Home (WGH) from Audubon (which facilities are both located on the same campus and are proximate to each other), either she or Ms. Jent should have driven over there and continued to fill out PD's Discharge Summary. In all, what the Appellant's response told Ms. Inman was that upon learning PD's chart was missing, the Appellant did nothing about it. According to Ms. Inman, that whole situation, and the Appellant's response thereto, made it appear as though the Appellant allowed her department to be run contrary to standard operating procedure and agency policy. Ms. Inman would have expected the Appellant to search for the chart when it was first discovered missing and once found, be certain it had been completely filled out.

16. Upon reviewing the Declination Form, marked as Appellee's Exhibit 3, Ms. Inman admitted that it looked like Ms. Madigan was the nurse who filled it out. When asked what the Appellant did wrong in this situation, Ms. Inman noted that given the Appellant was in charge of the Medical Department and had hired and trained Ms. Madigan, it was her responsibility to insure that her subordinates were following policy. In this instance, it does not look like the Appellant did anything to correct the error and just let it go. Whenever medications are discontinued, they should no longer be given or offered to a youth. Instead, the prescribing doctor or the admitting psychologist should have been called and the order to discontinue confirmed. In this instance there is only an alleged verbal report from the doctor to stop PD's medications. As Ms. Inman stated previously, "if it is not written in the file then it did not happen." According to Ms. Inman, this type of order should have been documented in writing. What concerned Ms. Inman the most was that PD had threatened suicide just two days before his transfer and it appears that the nursing staff was lackadaisical in trying to determine what was going on with him.

17. Appellee's Exhibit 8 was introduced through the witness and is a copy of PD's Discharge Summary from the Hopkinsville facility dated September 8, 2011. This is an example of a properly filled out Discharge Summary.

18. The next to testify at the hearing was **Ms. Kristie Stutler**, Juvenile Facility Superintendent of AYDC. Her main duty is to ensure that staff follows standard operating procedure. She also requests major disciplinary actions. Ms. Stutler is also the Appellant's direct supervisor. In this instance, Ms. Stutler prepared the request for Major Disciplinary Action (MDA) for the Appellant and sent the same to her supervisor, Teresa Morgan. From there, the request went up the line to the DJJ personnel department. On occasion, when she sends MDA requests, Mary Caldwell will ask her what type of discipline she would suggest. However, Ms. Stutler had no further involvement in deciding what disciplinary action was to be taken against the Appellant.

19. According to Ms. Stutler, the Appellant has oversight of the medical department at the AYDC. She supervises three nurses and is entrusted to insure that standard operating procedure is being followed so that the facility accreditation can be maintained.

20. On October 21, 2011, Ms. Stutler met with the Appellant after receiving Ms. Inman's e-mail marked as Appellee's Exhibit 7. Upon first reading the e-mail, Ms. Stutler did not think an MDA was necessary, but she came out of the meeting more concerned than when she came in and was somewhat alarmed by the Appellant's response. As such, Ms. Stutler decided to move forward with the MDA request due to the Appellant's lack of competence in the handling of these medical issues.

21. Appellee's Exhibit 9 was introduced through the witness and is a copy of the Appellant's response to the allegations regarding PD. This document speaks for itself. However, Ms. Stutler noted that therein, the Appellant admits she changed the time PD's prescriptions were given on her own without benefit of a doctor's order.

22. In addition, Ms. Stutler was not happy with the Appellant's response to being questioned about PD's medical file being unsecured. According to Ms. Stutler, rather than correcting or disciplining Ms. Jent for leaving the file out, the Appellant was nonchalant about the matter. Eventually, the Appellant did have a supervisory conference with Ms. Jent, but only at Ms. Stutler's direction.

23. Appellee's Exhibit 10 was introduced through the witness and is a copy of Ms. Stutler's MDA request against the Appellant.

24. Appellee's Exhibit 11 was introduced through the witness and is a copy of DJJ Policy Number 104. Specific reference was made to section IV(B).

25. Appellee's Exhibit 12 was introduced to the record and is a copy of DJJ Policy Number 402. Specific reference was made to section IV(C) with regard to the Appellant's failure to ensure that a Declination Form was signed each time PD refused to take his medication. Ms. Stutler stated this policy must be adhered to in order to maintain facility accreditation. Also noted was IV(D)(2) regarding the Appellant changing the time in which PD's medications were given without a physician's order.

26. Appellee's Exhibit 13 was introduced through the witness and is a copy of DJJ Policy Number 407 with specific reference being made to section IV(Q). Again, this had to do with there being no doctor's orders changing the time in which PD was to take his medication.

27. On cross-examination, after reviewing Appellee's Exhibit 12, Ms. Stutler stated that the Appellant failed to complete the Declination Form on the 16th and as a supervisor should have checked to see that on each day medications were refused that a Declination Form was filled out. Ms. Stutler also stated with regard to the failure to secure PD's medical files, that such files are to be kept under two locks, but on the day in question, the file was in an area where every employee had access to it. Ms. Stutler's real problem with this matter was that she had to prompt the Appellant to follow up with Nurse Jent regarding a supervisory counseling session. According to Ms. Stutler, the MDA request was made, not necessarily based upon each individual act noted, but as a whole, it appeared there was a lack of oversight in the department for which the Appellant was responsible for training of staff and ensuring that policy was followed.

28. Appellee's Exhibit 14 was introduced through the witness and is a copy of DJJ Policy Number I-05. Specific reference was made to section III(B) regarding the proper use of the Declination Form.

29. The next to testify was **Ms. Debby Curry**, who is the Nurse Administrator for the Department for Juvenile Justice. Her main duty is to help train nurse supervisors and to assist Ms. Inman. Ms. Curry helped train the Appellant when she first came to DJJ. Ms. Curry was in attendance during the October 21, 2011 meeting with Ms. Inman, Ms. Stutler, and the Appellant, regarding PD's chart. She was there to look to see if there was a ongoing pattern and to see if more training was needed. In this instance, after looking at PD's chart, she had several concerns starting with the lack of doctors' orders and nurses' notes.

30. Appellee's Exhibit 15 was introduced to the record and is a copy of DJJ Policy Number A-02 with specific reference being made to section II(K) regarding the Appellant's failure to properly supervise her subordinates. Appellee's Exhibit 16 was introduced through the witness and is a copy of DJJ Policy Number D-01, with specific reference being made to section III(A) and having to do with giving PD's medications at the time ordered by the doctor. Reference was also made to section IV(L) and section VI. Appellee's Exhibit 17 was introduced

through the witness and is a copy of DJJ Policy Number E-13, with specific reference being made to section III(5) and having to do with the proper completion of PD's discharge summary. Appellee's Exhibit 18 was introduced to the record and is a copy of DJJ Policy Number H-02, with specific reference being made to section II(B) and having to do with the failure to keep PD's file in a secured area with access being limited to authorized personnel only. Appellee's Exhibit 19 was introduced through the record and is a copy of the DJJ Medication Administration System found in its Health Service Protocol Manual with specific reference being made to sections 2 through 7, directing that no medications are to be administered without a physician's order.

31. On cross-examination, Ms. Curry stated that PD's progress notes should have demonstrated his doctor had discontinued his medications. The Appellant or her subordinate should have called the new treating physician to tell him about the previous doctor's orders to discontinue the medication and to determine whether or not the new treating physician wanted the meds continued or not. In this instance, there were no notes in PD's file to indicate that had occurred. Ms. Curry stated that she was not familiar with any standing order from a doctor directing that existing medications for youths should continue. The only standing order she is aware of is an admission order allowing for standard screening for STDs, etc. Upon this testimony, Appellant's Exhibit 2 was introduced through the witness. This appears to be a standing order dated February 12, 2009, indicating that staff was to continue current psychiatric/psychotropic medications until evaluated by the facility psychiatrist. Ms. Curry did not believe the standing order was found in PD's file. There are also no notes indicating that PD came or was transferred in with leftover pills. Appellant's Exhibit 3 was introduced through the record and is a copy of a similar standing order to that of Appellant's Exhibit 2 and is dated February 6, 2011. According to Ms. Curry, the first time she had seen these orders was during her meeting with Ms. Stutler, Ms. Inman and the Appellant.

32. The next to testify was **Ms. Mary Caldwell**, the Personnel Administrator with DJJ. Her duties include drafting disciplinary actions against employees.

33. Appellee's Exhibit 20 was introduced through the witness. Ms. Caldwell recommended that the Appellant be suspended for three days per DJJ's progressive disciplinary action policy. Ms. Caldwell considered that there was a previous disciplinary action taken against the Appellant. She also considered the Appellant's job duties and that with her higher rank came higher responsibility and a higher standard. According to Ms. Caldwell, it is important that the Appellant set the proper example for her subordinate employees. Appellee's Exhibit 21 was introduced to the record and is a copy of the Appellant's Position Description. This document was signed by the Appellant.

34. Ms. Caldwell testified she attempts to ensure that DJJ's disciplinary actions are consistent by charting every single disciplinary action taken, including all violations and the disciplinary actions meted out. She also keeps track of Personnel Board decisions in order to ensure that she is staying within customary levels of discipline.

35. In this instance, Ms. Caldwell stated that a three-day suspension was appropriate because just a month and a half prior, the Appellant received a one-day suspension. In this particular instance, where there were several instances of violations were being alleged, Ms. Caldwell thought that a three-day suspension was lenient. Appellee's Exhibit 22 was introduced through the record and is a copy of the suspension letter dated November 30, 2011. This letter was delivered to the Appellant and speaks for itself. Appellee's Exhibit 23 was also introduced through the record and is a copy of the October 3, 2011 one-day suspension letter delivered to the Appellant.

36. On cross-examination, Ms. Caldwell stated that she drafts the majority of suspension letters which are based on the allegations contained in the MDA requests and any other memo, documents or DJJ policies and SOPs attached thereto. She also always pays close attention to any employee response.

37. The next to testify was the Appellant, **Charlene Elston**, who is the Nurse Shift Program Supervisor at the AYDC.

38. According to the Appellant, PD had been to the AYDC before and was happy to be back. Upon his transfer, the Treatment Director had already determined that PD was not suicidal. Apparently PD said he had lied about being suicidal.

39. According to Ms. Elston, the standing orders marked as Appellant's Exhibits 2 and 3 were in place when she first arrived at AYDC. As such, there was no point in calling the doctor because the doctor will not change the youth's medications before evaluating him. Typically, the standing order goes into the youth's file. According to the Appellant, it was in PD's file because she saw it.

40. Regarding PD's allergy, PD told her that he had eaten a French toast stick back in Hopkinsville that made his throat itch. The Appellant stated she did not call Dr. Sheridan to order an EpiPen because this is usually done for peanut, shellfish, and bee sting allergies. Also, Audubon already had an extra EpiPen. According to the Appellant, Ms. Inman told her Dr. Sheridan was very upset that no EpiPen had been ordered. So she went on and e-mailed Dr. Sheridan, which was marked as Appellant's Exhibit 4. The Appellant did admit that she failed to document the cinnamon allergy on PD's Discharge Summary.

41. Regarding the failure to fill out the Declination Form, the Appellant stated that PD came to the Audubon with his medical chart and one pill of each medication. There were no doctor's orders but Ms. Crick had told the Appellant that PD's medications had been discontinued. PD also said he did not want to take his medications anymore because they did not help. Ms. Madigan performed the intake when PD arrived at AYDC and was the person who prepared the Declination Form, marked as Appellee's Exhibit 3. According to Ms. Elston, Superintendent Crick had asked Dr. Patel to fax her an order regarding PD's medication discontinuance and as far as the Appellant knew they were still waiting for the same. The Appellant did not see any problem with the way Ms. Madigan completed the Declination Form because they had a tentative or pending discontinuance order based upon Tanya Crick's verbal notification. The Appellant had her word and was just waiting on an official doctor's order. The staff kept offering PD his medication until the doctor's order finally came in on September 22.

42. The Appellant took it upon herself to change the time in which PD's medication was given because PD threatened to refuse his medications again unless he could take them in the morning. Since it was not a sedating drug, the Appellant did not have a problem with this. According to the Appellant, she has changed medication times 15 minutes here or there on several occasions so that youths would not fall asleep during church or movie night or AA meetings in the evenings.

43. Regarding the failure to properly fill out PD's Discharge Summary, the Appellant stated that after being told by Nurse Jent that PD had already been taken to the WGH, she called the lady at the WGH to inform her she had not had enough time to complete the Discharge Summary and went on to tell her what the group home needed to know about his medical history.

44. Regarding the medical file security, according to the Appellant, PD's file was on Mary Jent's desk located in the general room behind a locked door. Ms. Jent has been properly trained on file security. However, in this instance Ms. Jent had to leave the room in a hurry because someone in ACU had called and asked her to come down quickly. Since Ms. Jent was not with the file when the people from WGH came to get PD, she could not tell those people to wait until she was done with the Discharge Summary. Ms. Elston stated that she verbally counseled Ms. Jent regarding file security at the insistence of Ms. Stutler.

45. The Appellant admitted she should have been disciplined for not getting an official order allowing her to change PD's medication times and for failing to indicate on his Discharge Summary that he had a allergy to cinnamon. However, the Appellant did not believe she should have been disciplined for any of the other allegations contained on her suspension letter. As stated before, Ms. Jent was in the process of preparing PD's Discharge Summary when she received a call from ACU and had to come down there quickly. Apparently, the Youth Worker who came to pick up PD saw the file and picked it up before the Discharge Summary could be completed. The Appellant stated that she usually reviews the Discharge Summary, but

in this instance PD's transfer happened so quickly she could not.

46. Appellee's Exhibit 24 was introduced through the witness and is a copy of a Supervisory Conference held with Ms. Elston on December 10, 2009.

47. The Appellant testified that Ms. Jent had no previous disciplinary actions against her. She also stated that the people at the WGH were not upset because of the lack of information contained on the Discharge Summary. Also, Dr. Sheridan was not upset because the Appellant did not order an EpiPen as stated by Ms. Inman. In other words, according to the Appellant, Ms. Inman was being dishonest. The Appellant also stated that PD never exhibited any allergic symptoms.

48. This matter is governed by KRS 18A.095(1) which states:

> A classified employee with status shall not be dismissed, demoted, suspended, or otherwise penalized except for cause.

49. The Hearing Officer has considered the entire administrative record, including the testimony and statements therein.

FINDINGS OF FACT

1. The Appellant, Charlene Elston, a classified employee, timely filed her appeal with the Personnel Board on December 8, 2011, appealing her three-day suspension from duty and pay as a Nurse Shift Program Supervisor at the Audubon Youth Development Center on the basis of poor work performance.

2. The Appellant's duty as a Nurse Shift Program Supervisor included ensuring that she and her subordinates adhere to the Department of Juvenile Justice standard operating procedure and policy in order to ensure the quality and continuity of care provided to the youths served at AYDC and in order to maintain the facilities' accreditation.

3. On October 11, 2011, youth PD was released from AYDC and transferred to WGH.

4. On October 14, 2011, Louise Inman, the Nurse Service Administrator for the Department of Juvenile Justice, was filling in for the Agency nurse at the WGH when she came upon the medical file/chart of PD. When a youth is transferred from one facility to another, his or her medical file goes along with them, and in addition to being accurately documented, should include a properly filled out Discharge Summary form (such as the form marked as Appellee's Exhibit 1) which allows staff to readily assess the youth's medical background.

5. The Discharge Summary Ms. Inman found in PD's file/chart was not fully completed and, contrary to information known by the Appellant, indicated he had no known allergies (see Appellee's Exhibit 1). The Appellant was aware that PD claimed to have an allergy to cinnamon and failed to properly document the same on his Discharge Summary. The Appellant admitted she failed to properly document PD's allergies on his Discharge Summary (see Appellee's Exhibits 2 and 9).

6. PD was transferred from the Hopkinsville Group Home to AYDC along with psychotropic drugs, Sertraline and Abilify. These drugs were offered to PD by the nursing staff under the Appellant's supervision between September 8, 2011 and September 22, 2011. On September 8, PD refused to take this medication and the proper Declination Form was filled out and signed by PD (see Appellee's Exhibit 3). However, Declination Forms were not completed between September 9 and September 22 as required by DJJ policy and standard operating procedure, which requires that each refusal of a medication by a youth be documented and signed off on by both facility staff and the youth.

7. These psychotropic drugs were also offered to PD without benefit of a doctor's orders as required by DJJ policy and standard operating procedure which states that medications are to be administered only upon the order of a physician. There was no documentation in PD's file/chart to demonstrate that the facility psychiatrist had been notified that PD had been admitted and was using psychotropic medications. It was not until September 22, 2011, that Dr. Josephson discontinued these medications and began prescribing Wellbutrin on September 29, 2011.

8. On October 6, 2011, Dr. Josephson prescribed Abilify for thirty days to be taken by mouth at the hours of sleep. Rather than give the Abilify to PD in the evening as ordered, the Appellant took it upon herself to administer the same in the morning. The Appellant did not obtain the doctor's permission to alter his order.

9. PD's Discharge Summary forwarded to the WGH was not fully completed. Testimony indicates that the Appellant had directed her subordinate, Ms. Jent, to complete the Discharge Summary and that while she was in the middle of doing so, she was called away from her duty station. It was further determined that PD's medical file was left in an area available to all staff at the AYDC rather than being secured in an area available only to properly authorized medical staff. The Appellant was aware PD's file had been taken without the Discharge Summary being fully completed and did not know the whereabouts of the same until Ms. Inman contacted her on October 14, 2011. The Appellant made no effort to locate the file and properly complete the Discharge Summary contained therein and only counseled Ms. Jent regarding proper file security after being prompted to do so by her supervisor, Ms. Stutler.

10. PD's Discharge Summary was not completed accurately and his medical file/chart was not properly secured as required by DJJ's policy and standard operating procedure.

11. The Appellant was suspended from duty and pay, in accordance with the Appellee's progressive disciplinary policy, for a period of three working days, effective beginning December 7, 2011, and continuing on December 8 and December 9, 2011, as a result of the allegations of poor work performance more specifically set forth in the suspension letter dated November 30, 2011, and marked as Appellee's Exhibit 22.

12. The Appellant had previously received a one-day suspension on October 3, 2011, for poor work performance (see Appellee's Exhibit 23).

13. The allegations against the Appellant contained in the suspension letter (marked as Appellee's Exhibit 22) have been substantiated and constitutes a failure to strictly adhere to the Department of Juvenile Justice's medical protocol and its policies as more specifically set forth in said suspension letter.

CONCLUSION OF LAW

The Appellee has demonstrated by a preponderance of the evidence that the disciplinary action taken against the Appellant, the same being a three-day suspension from duty and pay as a Nurse Shift Program Supervisor at the Audubon Youth Development Center, for various instances of poor work performance as more specifically set forth on the suspension letter (marked as Appellee's Exhibit 22), was neither excessive nor erroneous and was appropriate under the circumstances.

RECOMMENDED ORDER

The Hearing Officer recommends to the Personnel Board that the appeal of **CHARLENE ELSTON VS. JUSTICE AND PUBLIC SAFETY CABINET, DEPARTMENT OF JUVENILE JUSTICE (APPEAL NO. 2011-269)** be **DISMISSED.**

NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13B.110(4), each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file exceptions to the Recommended Order with the Personnel Board. In addition, the Kentucky Personnel Board allows each party to file a response to any exceptions that are filed by the other party within five (5) days of the date on which the exceptions are filed with the Kentucky Personnel Board. 101 KAR 1:365, Section 8(1). Failure to file exceptions will result in preclusion of judicial review of those issues not specifically excepted to. On appeal a circuit court will consider only the issues a party raised in written exceptions. See *Rapier v. Philpot*, 130 S.W.3d 560 (Ky. 2004).

Any document filed with the Personnel Board shall be served on the opposing party.

The Personnel Board also provides that each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file a Request for Oral Argument with the Personnel Board. 101 KAR 1:365, Section 8(2).

Each party has thirty (30) days after the date the Personnel Board issues a Final Order in which to appeal to the Franklin Circuit Court pursuant to KRS 13B.140 and KRS 18A.100.

ISSUED at the direction of **Hearing Officer Geoffrey B. Greenawalt** this _____ day of January, 2013.

KENTUCKY PERSONNEL BOARD

_____
MARK A. SIPEK
EXECUTIVE DIRECTOR

A copy hereof this day mailed to:

Hon. Jamhal Woolridge
Hon. Brenda Dinkins Allen