

STATE PERSONNEL BOARD, STATE OF COLORADO
Case Nos. **2003B222(C)**

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

DEBRA A. BETANCOURT and LYNDA PAULEY,
Complainants,

vs.

DEPARTMENT OF HUMAN SERVICES, COLORADO STATE VETERANS CENTER,
Respondent.

Administrative Law Judge (ALJ) Stacy L. Worthington held the first day of the evidentiary hearing in this matter on September 9, 2003, at the 1525 Sherman Street, Denver, Colorado. The hearing concluded on September 22, 2003, at the State Personnel Board, 1120 Lincoln Street, Suite 1420, Denver, Colorado. Assistant Attorney General Melissa Mequi represented Respondent. Respondent's advisory witness was Cynthia Bostic, the appointing authority. Complainants appeared *pro se*. Each complainant filed a timely appeal of a disciplinary action. Though the disciplinary actions involved two separate and distinct issues, both appeals involved many of the same witnesses, who would have to travel a great distance to testify. The two appeals therefore were consolidated for hearing to serve the convenience of the witnesses.

MATTER APPEALED

Complainants appeal their disciplinary pay reduction of 10% for six months. For the reasons stated below, both disciplinary actions are **affirmed**.

ISSUE

1. Whether the disciplinary action against Pauley was arbitrary or capricious.
2. Whether the disciplinary action against Betancourt was arbitrary or capricious.

FINDINGS OF FACT

1. Complainant Linda Pauley is a licensed practical nurse (LPN) at the Colorado State Veterans' Center (CSVC) in Home Lake, Colorado. Pauley has been a LPN for seven years, and has been at CSVC for about 4½ years

2. Complainant Debra Betancourt, whose nickname is Joy, is a certified nurse aide (CNA) at CSVC.

3. Each complainant received a disciplinary pay reduction of 10% for a period of six months.

4. CVSC is different from most nursing homes. Because it serves veterans, its population is about 80% men; most nursing homes are about 80% women. CSVC's population is also younger than most nursing homes as it is receiving younger residents with brain injuries. The CVSC residents are probably gruffer than are residents of most nursing homes.

5. Cynthia Bostic is the CVSC administrator. Her mission is to provide excellent care to the veterans who have served us. She has promoted in-services, created staff development positions, and is working to improve the employees' communication and interpersonal skills.

Linda Pauley

6. On April 27, 2003, CSVC resident L.T. died. At 2:00 or 2:30 p.m., registered nurse (RN) Carolyn Carone was counting medications at one medication cart, and Pauley was counting medications at another cart with another LPN. Pauley said that someone had killed a resident. Carone asked who, and Pauley replied, "Your treatment nurse, Rebecca. You'll hear about it later."

7. Carone thought that Pauley's statement was ugly and uncalled-for. She had also observed a decline in morale at CSVC because of friction among employees. She decided to write a statement about Pauley's statement.

8. Carone waited until May 5, 2003, to submit the letter because she had to take some time before she could write a letter that was not full of emotion.

9. Joyce Turpin is an RN at CSVC. In April 2003, she worked as the charge nurse on shift I (day shift).

10. Turpin was in the dining room on April 28, 2003. She heard a lot of talk about the resident's death, and she asked Pauley what happened. Pauley replied, "She killed him."

11. There were other staff and residents around when Pauley made that statement.

12. That day, Turpin observed that everyone was up in arms. Staff members were refusing to work together and residents were not being cared for. Turpin thought something needed to be done because the whole unit was being affected by what was going on.

13. Turpin thought Pauley's comment was unethical and inappropriate because it occurred in a public place, where many people could overhear what Pauley said.

14. Turpin thought something needed to be done, so she wrote up a statement about Pauley's comment and gave it to Bostic.

15. Roy Moruzzi is the Director of Nursing at CSVC. Bostic told Moruzzi about the allegations that Pauley had accused another nurse of killing a resident and asked him to interview people who might know about the incident. Moruzzi interviewed Carolyn Carone, Joyce Turpin, John Sandoval, Geri Montoya, Sadie Archuleta, and some other employees. Bostic had told him to talk to Turpin, and Carone came to him on her own. Moruzzi asked each person if there was anyone else who might have knowledge about Pauley's statements, and they referred him to others.

16. Turpin, Carone, and Sandoval told Moruzzi that Pauley had told people that an employee had killed resident LT. Two other employees told Moruzzi they heard Pauley make similar statements, but they later recanted because they feared retaliation.

17. Moruzzi concluded that Pauley's statements were inappropriate because they would create a hostile work environment, create fear among the residents, and cast doubt on the facility. CSVC is in a rural location where information often becomes widely known. He would have expected a nurse to bring allegations of substandard care to his attention, rather than make public statements casting another employee in such a poor light.

18. Statements such as Pauley's can be very disruptive, especially when they occur in a public place like the dining room. The residents can hear the statements, and they may become fearful. It is not uncommon for residents to react to things they hear by not eating, not being able to sleep, and telling their families that they are unsafe. Pauley's statement could also disrupt staff morale, and could lead to liability for the nursing home.

19. Pauley knew that there was a proper forum for raising concerns about nursing care. In fact, she did talk to Bostic about her concerns. There was no legitimate reason for making her statement to others in a public area, where residents were present and might have been within earshot.

20. Pauley has excellent clinical skills and does a very good job clinically. However, she has problems with her interpersonal skills and her working relationships with other staff. She makes derogatory statements about other staff, criticizes their work, and does not listen to other employees' opinions.

21. When Turpin took the day charge nurse position, six to 10 staff members told her to watch her step because Pauley was hard to get along with and would make her life miserable. Most of those people warned Turpin that Pauley had run people off before, and if Pauley didn't like her, Pauley would get her fired. Pauley was the only nurse Turpin was warned about.

22. Turpin got along well with Pauley, but Pauley hurt her feelings a lot, about 30 times in six months. When Turpin, as the new charge nurse, would make a mistake, Pauley would criticize her and it felt like Pauley was attacking her.

23. Pauley received a “needs improvement” rating for treating others with dignity and respect, because she gossiped, spread rumors, mimicked others, talked derogatorily about co-workers, and caused problems for people. Director of Nursing Roy Moruzzi has attempted to counsel Pauley about these issues, but she becomes upset and will not finish the conversations. In their last performance planning meeting, Moruzzi told Pauley to avoid gossiping and saying hurtful things about others and to start getting along better with others.

24. Pauley’s co-workers frequently came to Moruzzi complaining that Pauley harassed and intimidated them.

25. Moruzzi gets reports from staff when they believe they are not being treated properly. Though Pauley gets along well with some employees, others have asked him to change their schedules so they don’t have to work with her and deal with her rumors, gossip, spying, second-guessing, and speaking ill of others.

26. The nurse whom Pauley accused of killing LT initiated a grievance against Pauley in early May 2003. The grievance accused Pauley of defamation, slander, lies, gossip, and threatening behavior that created a hostile work environment for other employees. The grievance was supported by written statements from three other nurses, who described many examples of Pauley’s hostile and inappropriate behavior. Carolyn Carone wrote a statement, which alleged that Pauley said, “your cross nurse tried to kill LT.” The grievance requested that Pauley be terminated. Bostic denied the grievance.

27. Bostic conducted a predisciplinary meeting pursuant to Board Rule R-6-10 on May 15, 2003. In the meeting, Pauley did not admit or deny making the statement, but said she did not remember. Another topic was discussed at the meeting, but Bostic only considered that issue as it related to Pauley’s credibility. Pauley had denied involvement in the other issue, but Bostic interviewed another employee who confirmed that Pauley had been involved in the other issue. Bostic considered this information as she assessed the credibility of Pauley’s statement that she did not remember making the statement about a nurse killing LT. She did not, however, impose discipline for Pauley’s involvement in the other issue.

28. After the R-6-10 meeting, Bostic conducted some additional investigation to confirm details of the content and context of Pauley’s statement and to confirm that Pauley had completed classes in communication and respect that were requirements of the prior corrective action. Bostic considered that Pauley showed no remorse, nor did she seem to recognize the severity of her conduct. Bostic also took Pauley’s lack of credibility into account. Bostic concluded that Pauley had made the statement, that her statement jeopardized the licensure of the employee Pauley accused of killing LT, that Pauley had exposed the other employee and the CVSC to liability, and that Pauley had threatened the well-being of the residents, the morale of the staff, and the reputation of the facility.

29. On November 30, 2001, Bostic had administered a corrective action to Pauley for stating her intention to cause trouble for her fellow LPNs and other comments that were critical of the other nurses. The corrective action required Pauley to attend training on communication or work environment, and to refrain from any inappropriate behavior that creates an

uncomfortable or hostile work environment. Bostic counseled Pauley for an hour about using her positive attributes to become a role model for other staff, rather than using her energy in a negative way.

30. Bostic believed that Pauley's statement violated her prior corrective action. CVSC administrators had worked with Pauley on her interpersonal skills through counseling, the performance management system, and the corrective action, with no success. In fact, Pauley's statement took her poor interpersonal and communication skills to a new level. Bostic decided to issue a disciplinary pay reduction in an effort to make Pauley realize the severity of her conduct, that she needs to think before she speaks, and that she will be held accountable if she does not. Bostic even considered termination, but there is a nursing shortage and Pauley has excellent technical skills. Bostic therefore took a lesser disciplinary action, a 10% pay reduction for six months, in hopes of giving Pauley incentive to improve her behavior.

31. The disciplinary action described in detail Pauley's statements that led to the disciplinary action, but incorrectly identifies the date of the incident as May 5, 2003. The transcript of the R-6-10 meeting, which occurred on May 15, shows that Pauley was aware of the timing of her statements. For example, on the first page of the transcript Bostic described the statement and asked Pauley if she said that. Pauley responded, "I don't know, honestly it's been 3 weeks or so...." LT died on April 28, which was nearly three weeks before the R-6-10 meeting.

32. At hearing, Pauley testified under oath that when she got the disciplinary action and saw the date of May 5, she wasn't aware of anything she had done that date that would have resulted in a disciplinary action. She testified that the first day of the hearing was the first time she knew when and where the incident happened. Because the letter described the incident, and because the incident was discussed in detail in the R-6-10 meeting, Pauley's testimony is not credible.

33. Throughout the hearing, Pauley was combative and argumentative. She never denied making the statement about another staff member killing LT. Her testimony was cagily designed to imply a denial without actually denying the statement, for example: "I do not remember making any kind of statement like that to that person."

34. Pauley's demeanor throughout the hearing demonstrated her poor interpersonal skills and supported Bostic's conclusion that she made an inappropriate statement without thought or care about the effect that statement might have on the residents, other staff, or LT's family. Pauley's conduct violated the prior corrective action and the staff code of conduct, which requires employees to serve residents with respect and courtesy and to inspire public and resident confidence in CSVC. The disciplinary pay reduction was a modest response to Pauley's misconduct.

Debra Betancourt

35. Some of the CSVC nursing home residents smoke. Residents who smoke safely and in compliance with smoking rules (such as observing no-smoking areas) are allowed to carry

their own cigarettes. However, some residents either are unsafe smokers (e.g., they fall asleep while smoking) or their families ask the nursing home to restrict their access to cigarettes. Those residents' cigarettes are held in the nurses' station, and were usually distributed by the nurses every hour during "smoke call," though other staff members could and sometimes did hand out cigarettes. The nurses and CNAs could decide to withhold cigarettes to address residents' behavior problems.

36. It is not unusual for the residents to yell at staff, but it is inappropriate for staff to yell or shake their fingers at residents.

37. Resident WB was a smoker. When he wanted cigarettes, he usually held up three fingers and yelled "Gimme three!"

38. Valerie Braun worked at CVSC beginning a month to six weeks before May 5, 2003. She was in the CWEP program, which is a transitional program for people entering the job market.

39. Braun took CNA classes before she came to CVSC. Her classes included training about resident abuse.

40. When Braun began at CVSC, she received orientation that included training on resident rights and abuse. The orientation included videos showing staff conducting proper procedures, which included a segment on how to recognize abuse. Braun was told that there may be residents who call staff names, but staff have to deal with that behavior.

41. On May 5, 2003, Braun was in the lounge working with residents in an exercise program. She was sitting by the window that overlooked the nurses' station. There are objects in front of the window that partially obscure the view of the nurses' station.

42. That morning, Braun heard WB say "Gimme three." She heard him say "Gimme three" again, so she looked out the window and saw a CNA standing at the nurses' station. The CNA, whom Braun did not know at that time, walked to the counter where WB was standing, bent over, shook her finger in his face, and shouted, "Mr. B, you're not going to get any cigarettes because you were so mean and rude to the nurses today."

43. Braun looked for Debbie Lopez, the co-worker who was providing Braun on-the-job training, to talk about what she had just seen. She could not find Lopez, so she stood in the lounge for a short time thinking about what she had just seen. She then walked out, gave WB one of her own cigarettes, and went to the activities office.

44. Braun found Lopez and the activities director, Connie Gonzales, in the office. Braun asked whether it was acceptable to deny residents their cigarettes. Gonzales did not reply, but Lopez said "no" and asked what had happened. Braun told them about what she had seen, and asked how she should report it. Lopez told her not to report it because nothing would be done. Lopez asked who the CNA was. Braun said she didn't know her name, but would show her later.

45. Later that day, Braun saw Betancourt. She recognized Betancourt because she had gotten a good look at her face and recognized her face, especially the size of her lips and a mole on her face. Betancourt has a mole on her face. Braun told Lopez that was the CNA she had seen. Braun asked Lopez for her name, but Lopez walked away.

46. Braun then asked Gonzales who the CNA was, and Gonzales said, "Joy."

47. That evening at home, Braun thought about what she had seen. The more she thought about it, the madder she got because she would not want her family treated like that.

48. Braun knew a CVSC employee in the medical records section from high school. On May 6, 2003, Braun went to that employee and asked where to report the incident. The other employee told Braun to go to Bostic. Braun wrote a statement about what she had observed and gave it to Bostic.

49. Bostic was surprised that Gonzales and Lopez did not send Braun to her when they heard about the allegations of abuse. She suspended Betancourt pending the investigation.

50. Bostic interviewed a group of five to seven residents who usually sit around the nurses' station. Some of those residents are able to accurately relate things they have seen and heard, but others are not. Resident AC said, "I saw someone pointing a finger at the man who yells all the time." AC did not know who the person was who pointed the finger, but did identify WB as the resident. AC knows Betancourt by sight and by name.

51. Bostic attempted to talk to WB alone, but WB refused to talk to her.

52. Bostic met with Braun again and asked if anyone else was present during the incident, and Braun said no. Bostic then talked to Gonzales, who confirmed that Braun had pointed out Betancourt.

53. Bostic went back to WB, this time taking along Moruzzi in hopes that WB would be more receptive if another man were present. Bostic explained to WB that she needed information to protect other residents from being treated badly. This time, WB said someone had yelled and pointed fingers at him. WB began to escalate and become angry, and refused to say who the person was.

54. Bostic concluded that the statements from AC and WB confirmed Braun's statement, and that there was resident abuse.

55. Bostic conducted a predisciplinary meeting pursuant to Board Rule R-6-10 on May 13, 2003. At that meeting, Betancourt said she was set up; there were people with agendas against her who fabricated the allegation. Betancourt listed people whom she believed had agendas, and Braun was not on the list. Betancourt said she never gives out cigarettes and did not give any to WB that day.

56. At the R-6-10 meeting, Bostic discussed an issue concerning an index card. That issue played no part in her eventual decision to take disciplinary action. Bostic also discussed allegations that Betancourt had made statements about a nurse killing LT, which are discussed further below.

57. Betancourt brought two witnesses to the R-6-10 meeting, Linda Pauley and Geri Montoya. Bostic did not interview either witness.

58. Both Pauley and Montoya testified at hearing.

59. Montoya testified that AC knows Betancourt, that another resident has sexually harassed CSVC employees, that she has seen nurses withhold cigarettes, that she was once reprimanded by a nurse for giving a resident cigarettes when he had cussed a nurse, and that she has never seen Betancourt give a resident cigarettes. However, Montoya did not provide any testimony about May 5, 2003, and none of the information she provided addressed what happened on that date.

60. Pauley testified that she was working on May 5, that WB was upset when he came into the dining room, and that from 8:00 to 9:30 a.m. she was in sight of WB for a total of 30-45 minutes. During that time, she was also performing duties in the nurses' station, hall, TV room, and elsewhere. WB was sitting in front of the nurses' desk for that entire time. Pauley also testified that WB received cigarettes after breakfast, and that while she was at the nurses' station, she overheard Joyce Turpin refuse to give WB cigarettes because of a previous interaction between them. Finally, Pauley testified that Turpin and Betancourt do not look alike.

61. After the R-6-10 meeting, Bostic went back to Braun and asked if there was any chance she had mistakenly identified Betancourt. Braun described the person she saw as having big lips and a mole, which is consistent with Betancourt's appearance. Braun said there was no chance that she had made a mistake.

62. Betancourt was the person Braun saw commit resident abuse, for the following reasons:

a. Braun testified credibly that she saw the face of the person who abused WB and that the person was Betancourt.

b. Braun's description of the person who abused WB was consistent with Betancourt's facial features.

c. Braun and Gonzales testified that, on the same day that she observed the resident abuse, Braun pointed out Betancourt and asked who she was. Braun testified credibly that the person she pointed out was the person who committed the abuse.

d. Braun was a new employee who did not know Betancourt. She had no motive to fabricate abuse allegations against Betancourt. On the other hand, Betancourt

had a motive to deny those allegations in hopes of obtaining a reversal of the disciplinary action.

e. There was a discrepancy in the testimony of witnesses concerning Betancourt's attire on May 5, 2003. Braun testified that Betancourt was wearing a purple outfit, but other witnesses testified that Betancourt was wearing a colorful outfit with fish designs as part of the CSVC Cinco de Mayo festivities. However, Betancourt also testified that she received a purple outfit for Mother's Day, which she wore to work. Braun's statement did not describe Betancourt's clothing on May 5, and no other witness testified to any contemporaneous account of the clothing worn by the abusive employee. There is, therefore, no conflicting account of the clothing worn by the abusive employee. The only reasonable conclusion is that Braun saw Betancourt wearing the purple outfit on a different day, and by the time of hearing four months later, she had confused that outfit with the one Betancourt was wearing on May 5, 2003.

f. Pauley's testimony concerning her observations on May 5 were given no weight because Pauley lacked credibility throughout her testimony, and because there was absolutely no evidence to corroborate her insinuation that Turpin was the actual culprit. Braun's strong positive identification of Betancourt and the corroborating evidence that she had asked who Betancourt was the day of the abuse incident outweigh Pauley's testimony.

63. Bostic knew that WB was very trying, and concluded that Betancourt had lost patience and blew up at WB, yelled at him, leaned forward, and pointed her finger at him.

64. This kind of conduct constitutes resident abuse because yelling, leaning forward, and pointing finger are intimidating.

65. That conduct constituted resident abuse and violated the CSVC abuse policy, the CSVC Code of Ethics, the Colorado Department of Public Health and Environment State Operations Manual for Long Term Care, and the Nurse Aide Practice Act, § 12-38.1-101 et seq., C.R.S.

66. Bostic reviewed complainant's personnel file. She found that Betancourt's performance evaluations showed problems with people skills, including a "needs improvement" rating on treating people with dignity and respect because she was not a team player with staff. She also found that Betancourt's CNA license was suspended more than 10 years before for verbal abuse of a resident.

67. Bostic administered a disciplinary action consisting of a 10% pay reduction for six months, effective June 1, 2003, with concurrent corrective actions that were not grieved and are not part of this appeal.

68. The disciplinary action also refers to inappropriate statements Betancourt made concerning the death of resident LT. At hearing, however, Bostic testified that those comments

were not part of the basis for the disciplinary action, which Bostic testified she issued only for the abuse incident. The abuse incident alone was sufficient to sustain the disciplinary action.

69. The notice of R-6-10 meeting was sent to the address in Betancourt's personnel file, which was an incorrect address. The notice of disciplinary action gave the wrong address for filing a Personnel Board appeal. However, Betancourt did not provide any evidence that she was harmed or prejudiced in any way by these mistakes.

DISCUSSION

A. Pauley committed the act for which she was disciplined.

Pauley was disciplined for making inappropriate, harmful statements about another nurse in an area where other staff heard her, and where residents could have heard her. Pauley did not present any evidence that she did not make those statements, and she did not even deny making the statements at the R-6-10 meeting or during the hearing. There is, therefore, no doubt that Pauley committed the act for which she was disciplined.

B. The disciplinary action against Pauley was not arbitrary, capricious, or contrary to rule or law.

An appointing authority's exercise of discretion can be arbitrary or capricious in one of three ways, namely: (a) neglecting or refusing to use reasonable diligence and care to procure such evidence as she is by law authorized to consider in exercising the discretion vested in her; (b) failing to give candid and honest consideration of the evidence before her on which she is authorized to act in exercising her discretion; or (c) exercising her discretion in such manner after a consideration of evidence before her as clearly to indicate that her action is based on conclusions from the evidence such that reasonable men fairly and honestly considering the evidence must reach contrary conclusions. *Lawley v. Dep't of Higher Educ.*, 36 P.3d 1239 (Colo. 2001).

There was no credible evidence that Bostic failed to procure evidence or failed to consider any relevant information. Moreover, Bostic's decision to discipline Pauley was not unreasonable. Pauley had a long history of inappropriate behavior and poor interpersonal skills, which were noted in her performance evaluations and in a corrective action not long before this incident. Pauley's conduct therefore violated agency policy and the specific directive she received in the prior corrective action, and was willful misconduct as defined by Board Rule R-6-9, 4 CCR 801. In deciding whether to impose discipline an appointing authority must take mitigating and aggravating factors, including a person's disciplinary history, into consideration. Board Rule R-6-6, 4 CCR 801. The discipline was a 10% pay reduction for a limited period of time, close on the heels of a corrective action, and thus demonstrates that the appointing authority was using progressive discipline to address an ongoing problem. The disciplinary action therefore was not arbitrary, capricious, or contrary to rule or law.

C. Betancourt committed the acts for which she was disciplined.

Betancourt was disciplined for resident abuse. There is ample evidence (eyewitness testimony by Braun and corroborating statements by AC and WB) that a CSVC employee did shout at WB, point a finger at him, and speak to him in an intimidating manner. Betancourt did not dispute that such conduct constituted resident abuse in violation of agency policy and regulations of other agencies. Betancourt did dispute that she was the person who committed the abuse, however. For the reasons stated in the Findings of Fact, it is more likely than not that Betancourt was the employee who engaged in the abusive conduct.

D. The disciplinary action against Betancourt was not arbitrary, capricious, or contrary to rule or law.

The same test is applied here to determine whether Bostic's exercise of discretion was arbitrary or capricious. Betancourt did produce evidence that Bostic failed to use reasonable diligence and care to procure such evidence as she is by law authorized to consider in exercising the discretion vested in her. Betancourt brought two witnesses to the R-6-10 meeting and requested Bostic to interview them. Bostic refused to talk to those witnesses. Her reasoning was that neither of those witnesses could assist in her determination whether or not Braun mistakenly identified Betancourt, and that talking to them would somehow breach Betancourt's privacy interest. One of the witnesses, Montoya, did not provide any evidence on that issue. The other, Pauley, did testify that she was present on May 5 and provided information about her and Betancourt's whereabouts and activities on that day. By failing to interview Pauley, Bostic did not procure evidence that she was authorized to consider in exercising the discretion vested in her.

However, that failure does not necessarily compel reversal of the disciplinary action. Due process requires that an employee with a property interest in her employment have a right to some kind of predisciplinary meeting before termination. *Cleveland Board of Education v. Loudermill*, 470 U.S. 532 (1985); *Dep't of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994). In *Loudermill*, the Court balanced the private interests of the employee in retaining employment, the governmental interest in being able to terminate unsatisfactory employees without undue administrative burdens, and the risk of erroneous terminations. The Court concluded that public employees with property rights in their positions are entitled to notice of the charges against him, an explanation of the evidence the employer believes supports those charges, and an opportunity to present her side of the story. "To require more than this prior to termination would intrude to an unwarranted extent on the government's interest in quickly removing an unsatisfactory employee." 470 U.S. at 546.

Board Rule R-6-10 describes the essential requirements for that meeting: the appointing authority must meet with the employee to notify her of the information about the reason for potential discipline, including the source of that information. The employee then has an opportunity to respond to the information. Because the appointing authority is not required to present witnesses or the full range of evidence against the employee, "there is a lack of due process in this pre-termination meeting. Such due process deficiency is sustainable only if there is opportunity for a post-termination evidentiary hearing before a neutral third party, at which the authority must present and support its case." *Kinchen v. Dep't of Institutions*, 867 P.2d 8, 11 (Colo. App. 1993), *aff'd*, 886 P.2d 700 (Colo. 1994).

Rule R-6-10 did not require Bostic to interview Montoya and Pauley, but she bore the risk of reversal if those witnesses provided evidence that her decision to take disciplinary action was erroneous. However, Bostic's failure to interview those witnesses did not violate due process. First, Bostic did conduct follow-up interviews of Braun, who certainly was present during the abuse, to ensure that she was not mistaken when she identified Betancourt. She also reviewed Betancourt's personnel file, which revealed that she had a history of poor interpersonal skills and resident abuse. Second, as the Court of Appeals stated in *Kinchen*, an employee receives only partial due process in the predisiplinary proceedings, and does not receive full due process until the hearing before a neutral third party. At that hearing, the two witnesses did testify, so Betancourt did receive all the due process she was entitled to receive. For the reasons stated in the Findings of Fact, their testimony did not outweigh that of respondent's witnesses.

There was no evidence that Bostic failed to give candid and honest consideration of the evidence she did receive, or that her decision to administer a 10% pay reduction for six months was an unreasonable response. In fact, Bostic testified that an official of the Department of Public Health and Environment questioned why she had not terminated Betancourt for her abusive conduct.

Betancourt's conduct violated agency policy and guidelines issued by regulatory bodies with authority over CSVC, and thus was willful misconduct as defined by Board Rule R-6-9, 4 CCR 801. In deciding whether to impose discipline an appointing authority must take mitigating and aggravating factors, including a person's performance history, into consideration. Board Rule R-6-6, 4 CCR 801. Bostic properly considered Betancourt's performance history and a prior license suspension for resident abuse. The disciplinary action was not arbitrary, capricious, or contrary to rule or law.

CONCLUSIONS OF LAW

1. The disciplinary action against Pauley was not arbitrary, capricious, or contrary to rule or law.
2. The disciplinary action against Betancourt was not arbitrary, capricious, or contrary to rule or law.

ORDER

Both disciplinary actions are affirmed.

Dated this 6th day of
November, 2003, at
Denver, Colorado.

Stacy L. Worthington
Administrative Law Judge
1120 Lincoln, Suite 1420
Denver, Colorado 80203

CERTIFICATE OF MAILING

This is to certify that on the ____ day of **November, 2003**, I placed true copies of the foregoing **INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE** in the United States mail, addressed as follows:

Debra A. Betancourt
9439 Road 101 South
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and via courier to:

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