

INITIAL DECISION OF THE ADMINISTRATIVE LAW JUDGE

ROBERT SHAW and SUSAN ZARLINGO,

Complainants,

vs.

DEPARTMENT OF HUMAN SERVICES,

Respondent.

Administrative Law Judge Mary S. McClatchey held the hearing in this matter at the State Personnel Board, 633 17th Street, Suite 1400, Denver, Colorado, on July 14, 15, 16, 21, 22, 23, 28, and 29, 2009. The matter was commenced on the record on July 1, 2009. The record was closed on the last day of hearing on July 29, 2009. Assistant Attorney General Michelle Brissette-Miller and First Assistant Attorney Vincent Morscher represented Respondent. Respondent's advisory witness was Viki Manley, Director, Office of State and Veterans Nursing Homes, Department of Human Services (DHS), and Complainants' appointing authority. Complainants appeared and were represented by Patricia Cookson, Esquire.

MATTER APPEALED

Complainants Robert Shaw (Shaw or Complainant) and Susan Zarlingo (Zarlingo or Complainant) appeal their disciplinary terminations from employment by Respondent Department of Human Services (DHS or Respondent). Complainants seek rescission of the disciplinary actions, reinstatement to their positions, back pay and benefits, and attorney fees and costs.

For the reasons set forth below, Respondent's actions are **affirmed** as to both Complainants.

A. Administrative Notice.

The Administrative Law Judge took administrative notice of Colorado Department of Regulatory Agencies, State Board of Examiners of Nursing Home Administrators, Rules and Regulations for Nursing Home Administrators, Rule 4, Grounds for Discipline, 3 CCR 717-1; and United States Department of Health and Human Services, Centers for Medicare & Medicaid Services, Title 42 CFR § 483.12.

B. Video Conferencing.

The Administrative Law Judge entered an order to take testimony by videoconferencing, on grounds that many of the parties' witnesses work and reside on the Western Slope of Colorado. Portions of the hearing were held in the video conferencing room at the DHS Grand Junction Regional Center, 2800 Riverside Parkway, Grand Junction, Colorado. Those who testified via video were able to see the attorney in Denver conducting the examination. In addition, the Administrative Law Judge, the parties, and counsel in Denver were able to see each witness in Grand Junction. There were no technical difficulties associated with the video conferencing, and utilization of this resource proved to be very effective.

PRELIMINARY MATTERS

On March 17, 2009, the Complainants' appeals were consolidated by agreement of the parties. On March 19, 2009, the Administrative Law Judge entered a Protective Order to maintain the confidentiality of residents of the Colorado State Veterans Nursing Home at Rifle (Rifle).

Complainants did not testify at hearing.

ISSUES

1. Whether Complainants committed the acts for which they were disciplined;
2. Whether Respondent's actions were arbitrary, capricious or contrary to rule or law;
3. Whether the disciplinary actions imposed were within the reasonable range of alternatives available to the appointing authority;
4. Whether Complainants are entitled to an award of attorney fees and costs.

FINDINGS OF FACT

General Background

1. Rifle is a long term care facility that is entirely self-funded through resident private payments, Medicaid and Medicaid, and grants. Rifle receives no general fund money appropriations from the State of Colorado.

Shaw

2. Complainant Robert Shaw (Shaw) has been the Nursing Home Administrator (NHA) at Rifle since March 1995. Shaw has had an exemplary performance history while at Rifle.

3. Shaw received an overall performance rating of Outstanding for the periods of 1994-1995 and 1998-1999. Both of these evaluations complimented Shaw as a highly committed and extremely hard working self starter. They also noted as areas for development his need to be more sensitive to the opinions and feelings of others, to voice concerns appropriately, and to become more assertive rather than aggressive in style.
4. During the performance period of 2003 – 2004, Shaw received a Commendable performance rating and assumed the Acting Division Director duties. Positive comments in the narrative section included the following: gifted leader; strong team player; operations expert in all aspects of business; highly committed; politically astute; good sense of humor; knowledgeable of national issues; extends interest and energy beyond own facility; proactive for Division at national and local levels; well respected; most knowledgeable expert on matters of long-term care service delivery in the Division; his knowledge base in programmatic, policy, and fiscal operations of nursing homes is of the highest caliber. The evaluation also noted that Shaw had become the lead expert to evaluate and address the major problems at the Fitzsimons State Veterans Nursing Home, directing a team of professionals from other facilities.
5. Critical comments on Shaw's 2003-2004 evaluation included the following: forceful personality, also a strength, sometimes intimidating; sometimes it is difficult for others to engage with him when in disagreement; tendency to sometimes confront in an aggressive manner; in times of crisis, he presents as impatient, overly assertive. This can be intimidating to others.
6. The evaluation also noted that Shaw had "struggled with a fiscal rules violation" but had addressed it.
7. Shaw is a large, tall man whose face is pinkish in tone. His appearance is intimidating to some people.

Zarlingo

8. Complainant Susan Zarlingo has been the Director of Nursing (DON) at Rifle since October 2002. Prior to this position, she served as Assistant Director of Nursing.
9. The DON position is responsible for assuring that Rifle residents receive appropriate care and treatment and that resident rights are protected.
10. Shaw and Zarlingo were friends and they worked closely together as a management team. They ran a tight ship which resulted in a history at Rifle of achieving very successful federal and state survey results until early 2008.

11. In 2003-2004 and several ensuing years, both Shaw and Zarlingo spent several months at a time at Fitzsimons in order to help improve operations and standards of nursing care there. They have been universally well regarded by their peers in the long term care community in Colorado for several years.

Regulations Governing Nursing Home Administrators

12. The Colorado Department of Regulatory Agencies has promulgated regulations governing the conduct of Nursing Home Administrators (NHA's). The regulations provide:
 - NHA's are responsible for compliance with all local, state, and federal laws and regulations;
 - NHA's are required to ensure a quality of care and quality of life that is consistent with the health and safety of the residents in the NHA's facility, and to promote care enabling each resident to attain or maintain the highest practicable mental, physical, and psychosocial wellbeing, to the extent it is consistent with the resident's wishes;
 - NHA's are required to protect resident rights as required by state and federal laws, including protection against abuse, neglect, and other mistreatment;
 - NHA's must foster effective communication and problem solving between management, staff, residents, family, community, and all parties involved to provide for residents' rights, health, safety, and welfare.

DHS Employee Code of Conduct

13. The DHS Employee Code of Conduct requires that employees demonstrate respect for all people and their ideas and commit to resolving conflicts; assist coworkers and customers in a positive manner and follow through on commitments to them; be committed to one's job and present oneself as a good role model; treat others as they wish to be treated; be considerate of fellow workers when performing job tasks; listen actively and share information in open, honest, and appropriate ways.

DHS Workplace Environment Policy

14. The DHS policy governing "Workplace Environment: Making CDHS a Great Place to Work," was promulgated in 2002 as a result of a Workplace Equity Survey. One of the key recommendations from the survey was to "reduce incidents of harassment, discrimination and abuse of authority." The policy prohibits harassment and discrimination.

15. The policy defines "Workplace Harassment" to include: "Abuse of authority is a type of workplace harassment and is described as improperly taking advantage of a position of authority to endanger an employee's job, undermine an employee's job performance, threaten an employee's livelihood, or interfere with or influence his or her career. It may include but is not limited to behavior such as yelling, belittling, reprimanding in front of other staff, or withholding information that an employee needs to perform duties."

DHS Workplace Violence Policy

16. DHS's Workplace Violence policy prohibits threats, harassment, and intimidation, which can include "oral or written statements, gestures, or expressions that communicate a direct or indirect intent to commit physical and or psychological harm."

DHS Fraud Prevention Policy

17. DHS's Fraud Prevention Policy is intended to "promote an environment of accountability for public monies, which starts at management and works its way through the organization." The Policy requires that all "suspected irregularities or behaviors believed to be evidence of fraudulent actions should be reported to the Audit Division"and requires the Audit Division to conduct all fraud-related investigations for the Department.
18. The Policy defines "Irregularity" as "Any behavior that violates appropriate CDHS rules, etiquette, ethics, best practices or fraud policy as it relates to fraud. Any dishonest or fraudulent act."
19. The Policy states that behaviors and actions may be considered fraudulent if the actions are:
 - secretive;
 - committed for the direct or indirect financial or personal situational benefit of the perpetrator or an associate of the perpetrator;
 - committed for the purposes of receiving kickbacks, secret commissions, or payment of any kind outside of CDHS remunerative policies;
 - in violation of the perpetrator's fiduciary duties to the victim organization;
 - costing the CDHS, CDHS stakeholders, and/or CDHS affiliates assets, revenue, or reserves in any manner inconsistent with current CDHS fiscal policies;
 - any dishonest or fraudulent act;
 - forgery or alteration of documents;
 - misapplication of funds or assets as defined in CDHS Policies and Procedures Manual;
 - impropriety with respect to reporting financial transactions;

- falsification of time sheets, overtime worked, or any misrepresentation of time worked in general;
- fraudulent statements;
- any similar or related irregularity

Ownership and Use of State Assets Policy

20. DHS's Ownership and Use of State Assets Policy mandates, "No state employee shall use state time, property, equipment, or supplies for private use or any other purpose not in the interests of the State of Colorado."

On-Call Pay Rule

21. State Personnel Board Rule 3-46 states that on-call pay is "for employees specifically assigned, in advance, to be accessible outside of normal work hours and where freedom of movement and use of personal time is significantly restricted." It indicates that the annual compensation plan for the State of Colorado publishes the list of classes eligible for on-call pay and the rate at which it is paid.
22. Under Rule 3-46, "A department head may designate eligibility for individual positions in classes not published and maintain records of such on call designations."

Federal Regulations and Rifle Policies Governing Transfers and Discharges of Long Term Care Facility Residents

23. Federal nursing home regulations promulgated by the United States Department of Health and Human Services, 42 CFR § 483.12, entitled "Admission, transfer and discharge rights," govern Rifle. Federal and state regulatory agencies enforce this policy through annual surveys of long term care facilities such as Rifle.
24. This regulation requires long term care facilities to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, unless the transfer or discharge is "necessary for the resident's welfare and the resident's needs cannot be met in the facility," or "the safety of individuals in the facility is endangered," or "the health of individuals in the facility would otherwise be endangered."
25. The regulation contains detailed notice provisions governing transfers and discharges designed to protect resident rights. Before transfer or discharge of a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing, and record the reasons in the resident's clinical record. In addition, the written notice must include: effective date of transfer or discharge;

location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; name, address and telephone number of the State's long term care ombudsman; how to notify the appropriate protection and advocacy agency for residents with mental illness; and the facility's bed hold policy.

26. In view of the importance of the bed hold policy, the regulation also requires that at the time of any transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed hold policy during which the resident is permitted to return and resume residence in the facility.
27. The regulation requires that written notice of transfer or discharge be provided to the resident, family, and legal representative at least 30 days prior to the transfer or discharge. The only exceptions to the 30-day notice requirement are: the health or safety of individuals in the facility would be endangered, or an immediate transfer or discharge is required by the resident's urgent medical needs.
28. The regulation requires that the facility "must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."
29. Rifle's policy entitled, "Notice Before Transfer/Discharge" includes the same provisions as the federal regulation. One key provision states, "The facility will provide sufficient preparation and orientation to the resident to ensure a safe and orderly transfer or discharge from the facility. This preparation may include assisting the resident and family in the selection of a new residence, communicating with the receiving facility regarding the care needs of the resident and reviewing the staff routines for handling a transfer and discharge with the resident and family to reduce unnecessary anxiety or depression."
30. Rifle's policy entitled, "Psychiatric or Mentally Disturbed Resident" contains requirements for emergency transfers. A resident must present an imminent danger to others or himself or must be gravely disabled in order to be transferred on an emergency basis. A physician's order must be obtained for a transfer to Colorado State Hospital, Pueblo, Colorado, for a 72-hour hold for evaluation. Or, the resident may be referred to the Colorado West Mental Health facility in Grand Junction for preliminary assessment prior to transfer to Pueblo.

Resident FB

31. Rifle customarily sent residents to St. Mary's Hospital Mental Health Unit in Grand Junction for psychiatric assessments and stabilization. Rifle occasionally utilized the services of Colorado West Mental Health.

32. On September 7, 2007, resident FB was admitted to Rifle. A 76-year old retired anesthesiologist and World War II veteran, FB had diagnoses of Alzheimer's Disease, hypertension, urinary incontinence, depression, and degenerative joint disease. He was not placed on the secure Alzheimer's unit.
33. On September 9, 2007, FB was physically and verbally aggressive towards male and female nursing staff. He wandered in and out of other residents' rooms. At 6:00 p.m. he attempted to choke another resident.
34. On September 17, 2007, FB was transferred to the secure Alzheimer's unit at Rifle for a less stimulating environment.
35. Senior Care is a Denver-based private company that provides contract medical services to long term care facilities, including Rifle. Senior Care sends a geriatric physician to Rifle for roughly one and a half days each week in order to visit the patients.
36. On October 1, 2007, Dr. Dublin, a Senior Care physician caring for FB, issued an order for Zyprexa to treat FB's psychosis and agitation. On October 8, 2007, Dr. Murphy, another Senior Care physician caring for FB, discontinued Zyprexa and ordered Risperadol M for dementia and issued an order, "do not hospitalize." In addition, FB's advance directive was changed to comfort measures.
37. On October 11, 2007, Dr. Wasserman, another Senior Care physician, issued an order for Valium 5 mg (milligrams) for FB's aggressive behavior. On this day, FB fell in his room and when the nurse aide arrived to help him up, he grabbed her crocheted lanyard and pulled on it, became agitated, and grabbed her pen and tried to stab her with it.
38. Also on October 11, 2007, after the first administration of Valium was unsuccessful in curbing FB's aggressive behavior, Rifle nursing staff contacted Senior Care by telephone and obtained an order for Valium 10 mg every four hours as needed. This is a heavy dose of Valium.
39. Zarlingo called Dr. Dublin and informed her that Rifle sought to transfer FB out of Rifle because of his aggressive behaviors. Zarlingo asked Dr. Dublin to call the Emergency Room at the Medical Center at Aurora South (Aurora South) and stated there was no inpatient psychiatric team at the Grand Junction hospital.
40. Dr. Dublin called the Aurora South ER and spoke with the case manager, who stated they would not take the resident due to insurance issues. Dublin then spoke to the ER psychiatrist and explained that the resident needed stabilization for aggressive behaviors in an inpatient setting because she was unable to give large doses of psychotropic (antipsychotic) medications at the nursing home.

41. The Aurora South doctor asked if Rifle would accept FB back if they stabilized him. Dr. Dublin then spoke with Shaw and Zarlingo and they said yes, they would accept him back, it is his home.
42. FB's medical chart contains an October 12, 2007 telephone order from Dr. Dublin, "Send resident to Aurora South ER to evaluate psychiatric status and stabilize."
43. JB was FB's Medical Durable Power of Attorney (MDPOA) and FB's ex-wife.
44. On October 12, 2007, a nurse at Rifle left a message on JB's cell phone informing JB that Rifle was transferring FB to Aurora South. JB was on vacation at the time. On October 14, 2007, JB noted Rifle's number on her cell phone and called Rifle at that time. She then learned of the transfer for the first time.
45. FB's medical chart contains an October 12, 2007 entry by an SS (Social Service or social worker) staff member indicating that JB was called and a message was left to notify her of the transfer of FB.
46. FB's medical chart also contains a second October 12, 2007 SS entry stating, "SS called JB, FB's MDPOA to let her know of the pending transfer (to Aurora South ER). She (JB) expressed her feelings of disappointment and her wish that he remain at SCVNH. She was informed that she could happily reapply for admission here after his mood/behavior has stabilized."
47. Neither Shaw nor Zarlingo directed Rifle staff to provide the required written notice of transfer and notice of appeal rights to FB and JB in October 2007. No one provided the written notice.
48. On October 12, 2007, Shaw contacted the police department in Rifle in order to make a report of FB's assault on the staff member. The police report indicates that it was the intention of Rifle staff to have FB committed to a psychiatric institution for an involuntary 72-hour hold. No Rifle staff attempted to arrange to have an ambulance transport FB to Aurora South.
49. Shaw and Zarlingo ordered two staff members, Ken Henderson and Brian Crowe, to drive FB to Aurora South in the state-owned facility car, a Dodge Intrepid, drop him off there, and return to Rifle.
50. Crowe was a Maintenance staffer at Rifle.
51. Henderson was a Therapy Assistant, Certified Nurse Aide, and transportation advisor for Rifle. Having started at Rifle in February 2004, Henderson had obtained his nurse aide training on the job, become certified as a nurse aide, and had then progressed to become a Therapy Assistant. Henderson had also been a "first responder" until some time in 2007, which enabled him to provide

emergency medical assistance to patients under the supervision of medical personnel. Henderson was not certified to administer medications.

52. FB was given two 10mg doses of Valium for anxiety, at 12:45 p.m. and 3:45 p.m. on October 12, 2007 prior to the trip to Denver. Zarlingo and others prepared the back seat of the car with pillows and blankets. Shaw escorted FB to the car with Henderson and Crowe. FB was cooperative and composed. Shaw handed Henderson an envelope with \$300.00 cash to cover the hotel and food costs in Aurora.
53. Crowe drove the car while Henderson sat in the back seat with FB during the four-and-a-half hour transport. Henderson had with him a "face sheet" with FB's medical information, the Medication Administration Record, and the Treatment Administration Record. He did not have a complete copy of FB's medical record in his possession.
54. Henderson had none of FB's medications in the car with him. The only emergency supplies in the car were basic necessities for an elderly resident: incontinence pads, a wheelchair, and pillows and blankets. If FB had needed medical attention, Crowe would have had to drive to the nearest emergency room at a hospital. The drive went smoothly.
55. Upon their arrival at the Aurora South emergency room (ER), FB became agitated. Henderson decided to leave FB in the car while he went to register.
56. Henderson entered the ER registration area and was surprised to learn that the staff were not expecting FB and knew nothing about him. Staff asked several medical questions relating to FB, because they were unclear on what Rifle sought to have Aurora South do with him.
57. Henderson gave Aurora South staff the documents he had on FB and the telephone numbers for Rifle and Senior Care.
58. Aurora South staff kept reaching different Senior Care doctors who knew nothing about FB. Dr. Dublin was on vacation that day.
59. Aurora South staff called the night nursing staff at Rifle throughout the evening. Rifle staff called Zarlingo at home regarding the calls. Zarlingo told the nurses to refer Aurora South staff to Senior Care.
60. Aurora South staff placed FB in a triage room. A doctor entered the room and asked medical questions which Henderson was unable to answer. Henderson again referred the doctor to Senior Care and Rifle. The doctor left the room. Henderson felt under duress. He knew that Aurora South staff needed and was not receiving information on FB.

61. Henderson called Zarlingo at home and informed her of the situation. She directed Henderson and Crowe not to disclose her name to Aurora South staff. She did not offer to speak with Aurora South personnel about the care and treatment of FB and never contacted Aurora South regarding the care and treatment of FB.
62. Henderson informed Zarlingo that hospital staff wanted them to stay with FB. Zarlingo responded, "This is how the system works. You've got to get out of there." Henderson and Crowe felt uncomfortable leaving.
63. When the Aurora South staff returned, Henderson told them that his supervisor had ordered them to leave the patient there and to leave. Staff responded by telling Henderson and Crowe to wait. Then, a male nurse and a male security guard entered the room to make sure that Henderson and Crowe didn't leave.
64. Henderson called Zarlingo again. Henderson told her that the hospital staff did not want them to leave but he had told them that they had been told by their supervisor to leave. Zarlingo responded, "You didn't give them my name, did you?" Zarlingo stated that the doctor's order was to have FB admitted and that was what the doctor wants.
65. Aurora South ER staff charted the following notes on FB on October 12, 2007 at 8:41 p.m.: "attempting to get more information from transferring facility. Kenneth and Brian from Colorado state veteran's facility at bedside. Aware of need to remain with pt until their supervisor contacts charge nurse, Kiva. Attempting to obtain more information on reason pt at this facility. Security at bedside."
66. Aurora South staff attempted to get Henderson and Crowe to stay. The staff stated that if they left it would be "abandonment."
67. Henderson called Zarlingo one more time. Zarlingo stated, "Ken, get the hell out of there."
68. Henderson and Crowe discussed the situation and decided that since they had no way to care for FB through the night, they would leave. They told the hospital staff that they were leaving because they had been ordered to do so by their supervisor. As they started to leave, hospital staff followed them down the hall.
69. At 9:18 p.m., October 12, 2007, the Aurora South ER staff charting on FB states, "caregivers no longer at bedside. Unable to find them on hospital grounds. Charge nurse aware."
70. Henderson and Crowe drove away and then pulled over in the car to recover from the experience. They had trouble eating and sleeping that night and returned to Rifle early the next morning.

71. On October 13, 2007, Shaw called Henderson to his office, praised him for his work performance on October 12, and stated he was giving Henderson a \$20.00 per hour raise. The raise never occurred.
72. Aurora South did not conduct the assessment of FB. It transferred FB to Exempla West Pines, where FB was given a psychiatric assessment and was stabilized.
73. Once FB was stabilized, West Pines contacted Rifle to arrange for FB's return. Shaw and Zarlingo refused to accept him back. Shaw and Zarlingo ordered staff to fax to West Pines a document requiring that FB re-apply for admission to Rifle as a condition of returning.
74. On October 16, 2007, a social worker at Rifle spoke to JB to inform her of the FB's admission to West Pines and that FB was being discharged from Rifle and would need to re-apply for admission to Rifle. Rifle staffer Jessica Strong faxed an 8-page Application for Admission to JB.
75. On October 16, 2007, FB was listed as a "discharge" in the Rifle medical record. On October 12, 2007, FB had been listed as a "transfer" in the Rifle medical record.
76. On or about October 17, 2007, Barbara Kennedy, the Social Worker at Rifle, met with Zarlingo to discuss FB's discharge plan prior to sending it to West Pines. Zarlingo instructed Kennedy not to send a discharge plan or summary to anyone. Zarlingo said that the discharge to West Pines by Aurora South had been the responsibility of the staff at Aurora South. Kennedy disagreed.
77. Kennedy and Zarlingo reviewed the federal regulations on discharges/transfers and Kennedy asked if she should make a call to Michelle Lefebvre, the State Ombudsman. Zarlingo responded that if Kennedy did she would be "asking for trouble – personally, not the facility's trouble."
78. Kennedy then met with Shaw. He confirmed that FB would not be accepted back at Rifle unless he went back through the process of applying for admission, which would include an evaluation of his stability and whether they could meet his needs and keep staff and residents safe. He suggested that Kennedy call the State long term care Ombudsman and inform her of the level of violence that FB had demonstrated at Rifle, which formed the basis for their decision not to accept him back.
79. Kennedy left a message for the Ombudsman and sent her an email asking her to call her as soon as possible.
80. The case manager from West Pines then called Kennedy and stated that Rifle had to accept FB back at the facility and give FB and his family the 30-day

notice, rather than requiring him to go through the process of readmission/re-evaluation. She stated that if Rifle did not accept him back by the end of the week, she would call the state Ombudsman's office and "report them."

81. The West Pines case manager asked to speak with Shaw. Shaw refused to talk to her and stated to Kennedy that the case manager would not be happy no matter what he said to her because he was not going to agree to have FB transferred back to Rifle at that time.
82. Kennedy made notes of the above events on her computer and never printed them. She was very uncomfortable about the decision not to accept FB back at Rifle. The notes were later found by Janet Dauman, Director of Quality Management in the Office of State and Veterans Nursing Homes, when she investigated the FB incident.
83. On approximately October 20, 2007, Dr. Dublin received a telephone call from Shaw and Zarlingo. They informed Dr. Dublin that Rifle would not accept FB back at the facility. Within five minutes of that call, Dr. Dublin received a call from the ER psychiatrist at Aurora South indicating that the resident had been stabilized at West Pines, Rifle refused to take FB back, FB was upset that he would not be returned to Rifle, and that they were having difficulty finding a placement for FB.
84. Shaw and Zarlingo informed Dr. Dublin that FB's family wanted him to be in the Denver area.
85. West Pines staff attempted to contact Shaw at 10:40 a.m. and 3:55 p.m. on October 29, 2007. Shaw refused to accept the calls and did not return the calls.
86. West Pines staff attempted to contact Zarlingo at 3:55 p.m. on October 29, 2007. Zarlingo refused to take the call and did not return the call.
87. Dr. Dublin believes that Shaw and Zarlingo engaged in patient abandonment of FB at Aurora South.
88. FB was ultimately placed in a Denver area facility where he declined rapidly and died two months later.
89. Neither Shaw nor Zarlingo directed Rifle staff to provide the required written notice of discharge and patient rights to FB or JB at any time. No written notice was ever provided.
90. On October 29, 2007, Zarlingo ordered Joyce Wright, RN, to write a new order in FB's medical record. Zarlingo told Wright the October 16, 2007 discharge order needed to be clarified and told her exactly what to write. It states, "Clarification order: DC [discharge] order written 10/16/07 to Discharge res. [resident] to

Exempla West Pines due to res. was previously discharged to Aurora South Emergency Rm. For psych eval. and stabilization, telephone order Dr. Wasserman/Dr. Dublin taken by Joyce Wright, RN.”

91. On November 13, 2007, Crowe, the maintenance worker who had driven the car to Aurora South, wrote a letter to Viki Manley, Director of the Office of State and Veterans Nursing Homes for DHS. Crowe had resigned on November 2, 2007. In his letter, he stated that he and another staff member had been instructed by Zarlingo to bring FB to a hospital in Denver and to abandon him there. He also mentioned several problems with the Rifle management, alleging insurance fraud relating to air conditioning units and corruption.
92. Manley discussed the letter with John Johnson, Shaw’s direct supervisor. Manley did not follow through on the letter until several months later, when she was advised of other problems at Rifle.

Insurance Claim for Air Conditioning Units

93. In 2007, most of the air conditioning (AC) units in the Rifle facility were twenty years old, and some of them were wearing out. In the spring of 2007, staff at Rifle purchased two AC units for the facility. Because the units were made to order, they took several months to be delivered.
94. Prior to the delivery of the two new air conditioning units, on July 14, 2007, lightning struck an electrical power source for the Rifle facility.
95. One AC unit at Rifle was damaged by the lightning strike on July 14, 2007.
96. Crowe, a certified air conditioning repairman, was asked to go through all the rooms and inspect the HVAC units for lightning damage. He found one unit that was damaged due to lightning. It was a newer unit that had not been set up with surge protection. All of the older units had surge protection and were guarded against an electrical surge. Crowe also found nine to eleven AC older units that were not operating well.
97. Crow informed his supervisor, Physical Plant Manager Tom Elkins, and Shaw that one unit had been damaged by the lightning strike and that there were nine to eleven other units that were not damaged by the lightning but were not running well. Crowe gave Shaw and Elkins a list of the rooms that had poor units not damaged by lightning.
98. On Saturday night, July 16, 2007, Elkins contacted Lennie Goodman, a former six-year employee at Rifle who had opened his own electrical services business, “Lenny’s.” Elkins asked Goodman to come to Rifle and assess the damage by the lightning. Goodman came in right away. He believed that the lightning had

not struck the building, but had hit the main power source right outside of the facility.

99. The next day, Goodman returned. Crowe showed Goodman the one AC unit that had been damaged by lightning. Goodman did not tour any rooms to determine if other units had been damaged.
100. Goodman gave Crowe a blank invoice on Lenny's company stationary, for replacement of AC units to use for Rifle's insurance claim. Goodman typed at the top of the invoice, "INVOICE/SPREADSHEET. COLORADO STATE VETERAN'S NURSING HOME. . . 25 July 07. SUBJECT: Residents' room HVAC units. The below listed room HVAC units are unserviceable due to the lighting (sic) storm and resulting phase failure of 14 July 07 at approximately 2000 hours – 2130 hours. Further testing of generator/transfer equipment is needed to determine damage (if any) to this equipment. Regards, L.Goodman." At the bottom of the invoice was "LENNY'S" with the address and phone number for the business.
101. Goodman signed the blank Lenny's invoice before handing it to Crowe.
102. Crowe gave the blank, signed Lenny's invoice to Elkins. Elkins filled in the invoice with twelve resident room numbers, to indicate that twelve AC units at Rifle had been damaged by lightning. He also wrote \$210.00 as the price for Goodman's assessment of the AC units.
103. On July 17, 2007, Kevin Ross, DHS Manager of Projects, asked Bill Ledbetter, Safety, Claims and Contract Coordinator for DHS, the individual responsible for filing insurance claims on behalf of the agency, to call Shaw in order to assist with an insurance claim.
104. On July 17, 2007, Ledbetter called Shaw. Shaw informed Ledbetter that the Rifle facility had been hit by lightning and required filing for emergency assistance, insurance claims, etc. Shaw informed Ledbetter that the Rifle facility had lost six air conditioning (AC) units, dishwashers, a wheel chair washer, phones, elevators, emergency lights, and all electrical control boxes appeared to have been damaged.
105. Ledbetter agreed to assist with the claim and planned to come to Rifle to assess the damage subject to the insurance claim on July 19, 2007. In addition, Dennis Buck, Facilities Manager for DHS in the Denver office, arranged to have an electrician and an HVAC expert accompany Ledbetter to the Rifle facility. When the Grand Junction Facilities Manager, Rod Sessum, learned about the two experts accompanying Ledbetter to Denver, Sessum objected strongly on "turf" grounds. Buck cancelled their trip with Ledbetter in order to permit Sessum to handle it.

106. On July 19, 2007, Ledbetter visited the Rifle facility alone to assess the damage for purposes of filing the insurance claim. Shaw directed Ledbetter to tour the facility with Crowe because Elkins was on vacation. Ledbetter examined only one damaged unit that had already been removed from the facility and placed in the shop. He took pictures of that one unit, did not tour any other rooms, and returned to Denver.
107. Following his visit, on July 19, 2007, Ledbetter emailed Shaw and informed him of the information and documentation he needed prior to filing the insurance claim. He stated in regard to the AC units, "Brian Crowe said he had replaced the leads on the air conditioners and re-set them and they appear to be running normal." Ledbetter asked for photos of any damaged AC units.
108. In his July 19, 2007 email to Shaw, Ledbetter noted Shaw's request that the electrician and HVAC expert accompany him from Denver. Ledbetter directed Shaw to Sessum. Shaw never asked Sessum to send an electrician or HVAC expert from the Grand Junction office to assess the AC unit damage from the lightning.
109. Elkins submitted the Lenny's invoice for 12 AC units and a purchase order for eleven AC units to Ledbetter.
110. On July 26, 2007, Ledbetter sent Shaw a second email request for pictures of the damaged AC units, entitled, "Information to File Claim."
111. Shaw immediately replied to Ledbetter and Elkins, informing Ledbetter that Elkins would assemble all pertinent information for him.
112. On August 13, 2007, Ledbetter sent an email to Elkins, copying Shaw, Ross, and Buck. Ledbetter stated in part, "I also need a written quote for the replacement of the Room-HVAC systems. I have what you sent which was 12 units @ \$994 each. I will need a written quote to turn in. It will need to have unit model number, number of units, price per each and be a quote from a valid vendor. Have these been replaced? If so, a copy of the actual invoice will work." (Emphasis in original.) On August 15, 2007, Ledbetter sent another email to Elkins requesting written documentation for the AC units.
113. Elkins provided Ledbetter with a copy of the Purchase Order to DWG, Inc. for twelve air conditioning units. Ledbetter used the Purchase Order as the basis for submission of the insurance claim on behalf of Rifle.
114. Shaw did not assure that Ledbetter received photographic evidence of the twelve damaged AC units, despite Ledbetter's repeated requests for it. Shaw knew that only one unit had been damaged by the July 14, 2007 storm.

115. DHS purchased eleven air conditioning units from DWG, Inc. for \$1,272.00 each and a total of \$13,992.00 on August 3, 2007.
116. On November 8, 2007, DHS received insurance proceeds for the lightning strike in the amount of \$12,743.03, the full claim amount minus a \$10,000 deductible.
117. Prior to the delivery of the new AC units purchased with the insurance proceeds, Crowe fixed several of the air conditioning units that were in poor condition by replacing switches and Freon. The cost of this repair work was over \$3000.00.
118. By the summer of 2008, the eleven new AC units bought with insurance proceeds were delivered to Rifle. One of the new units was installed.
119. Ten of the new AC units purchased through insurance proceeds were placed in the storage shed and remained unopened in their shipping boxes. They remained in that location indefinitely for future use.

Work Environment at Rifle

120. Shaw and Zarlingo's absence from Rifle for extended periods of time to assist at Fitzsimons created distance between them and the subordinate staff.
121. The management styles of both Shaw and Zarlingo also caused many staff to fear them. Many, if not most, Rifle staff found Shaw and Zarlingo to be unapproachable and were fearful of asking them questions or interacting with them.
122. When many staff asked to talk to Shaw and Zarlingo, they often responded that they were too busy. Shaw and Zarlingo had favorites and Rifle staff were aware of who those favorites were.
123. During the last few years, Shaw has kept his door shut when in the building and has seldom been seen anywhere in the facility by staff. In the first period of Shaw's tenure as NHA at Rifle, he was accessible to staff. By approximately 2003, he rarely interacted with any staff at Rifle. Some staff had never met Shaw after working at Rifle for an entire year.
124. Many of the staff at Rifle grew increasingly fearful of and intimidated by Mr. Shaw because of his inaccessibility. Rumors about Mr. Shaw circulated widely. Most of them were untrue.
125. At Management Meetings, Shaw was not open to suggestions from his management team. He often responded that there was no time to discuss an issue raised by one of his managers. Zarlingo often stated, "You are all replaceable" to those in attendance at Management Meetings. She also made

this statement in meetings with nurses and nurse aides. At one nurse aide meeting, Zarlingo stated, "Every single one of you is replaceable."

126. Shaw was at times supportive of those who approached him for assistance in performing their jobs. He sometimes stated, "What can I do to help you do your job?"
127. If Zarlingo was under stress or pressure at work, she yelled at the nurses under her supervision in front of other staff or residents or both, or in her office with the door closed. She did not yell at her staff on a routine basis.
128. The Office Manager at Rifle, Kim Coppock, had a poor working relationship with her subordinates and often belittled them for asking her questions. Coppock withheld information from subordinates that they needed to perform their duties. Coppock also insulted or reprimanded Rifle employees who asked her questions.
129. One of the Maintenance crew at Rifle, Mike Walker, was so intimidated by Coppock because of her history of rude treatment that he never obtained health insurance through the State. He had no access to email in his position and was too fearful to ask for her assistance with the "Open Enrollment" process.
130. At least two of those working under Coppock's direction were unclear on their job duties and were too afraid to ask her clarifying questions.
131. Several Rifle employees complained about Coppock to Shaw. Shaw was aware of Coppock's harassing and intimidating behavior towards others but did not take action to address it. Manley directed Shaw to address the problem with Coppock. Shaw talked to Coppock but allowed the behavior to continue.
132. Rifle employees also complained to Shaw about Zarlingo's supervisory style. He discussed the issue with Zarlingo but otherwise did not take action.

Lori Seim and May 2008 Meeting

133. Lori Seim was the Business Manager for the Office of State and Veterans Nursing Homes in the Denver headquarters office. One of her duties was to visit Rifle every month to oversee its accounting and finance functions. Seim noticed that the stress level of those working under Coppock was very high and that at least two employees were unclear on their job duties and too intimidated to ask for clarification. For example, Seim asked Dianne Dayhoff if she could do a certain task. Dayhoff's response was that she didn't know if Coppock would allow her to do that.
134. Seim observed that the fearful work environment had an adverse effect on the quality of work of the front office at Rifle. Seim spent a lot of extra time training and re-training the Rifle staff who reported to Coppock. Seim was concerned,

because she had to assure that the financial and accounting functions in Rifle were correct and that staff were able to do their jobs competently.

135. During Seim's May 2008 visit to Rifle, front office personnel approached Seim tearfully, stating they didn't know what their jobs were. Seim decided to raise the issue with Shaw.
136. Seim arranged to speak with Shaw with Coppock present. Seim informed Shaw that the employees in the front office were fearful of losing their jobs and felt they did not have the authority to do their jobs. Shaw became angry with Seim and was unwilling to discuss the concerns she had raised with him.
137. Seim was upset by her meeting with Shaw and Coppock. She returned to the back office and called Manley, her direct supervisor. Seim explained the problems in the front office at Rifle and said indicated that the meeting had not gone well.
138. Manley informed Seim that she would support Seim in either continuing to perform her work at Rifle, or in returning to Denver. Seim decided to return to Denver. Shaw then approached Seim and stated that he did take her statements seriously and was convening a meeting with the front office staff that day.
139. Shortly thereafter on the same day, Shaw convened a meeting of all of the front office staff who reported to Coppock. In attendance were Shaw, Coppock, Seim, Nikki Maynard, Dianne Dayhoff, Lisa Reed-Scott, and Angie Tonnizi-Lee.
140. Shaw opened the meeting by stating that Maynard would document what was said at the meeting by taking notes. He then informed the group that Seim had informed him that several of the front office staff felt threatened and harassed in their jobs.
141. Shaw went around the table and asked each person a series of questions to answer in the presence of the others: "How long have you worked here? Have I ever done anything threatening? Have you ever felt afraid while working here? Do you consider it a hostile environment working here?"
142. No one at the meeting felt comfortable.
143. Tonnizi-Lee stated that she didn't know exactly what her job was. Shaw directed her to meet with Coppock. Dayhoff stated that she agreed with Tonnizi-Lee, that she was more than willing to do her job but did not have the requisite training to do it. Shaw told her to work through her supervisor to get the tools and training necessary to do her job. Shaw also stated to Dayhoff, "We'll discuss that later." Shaw never followed up with Dayhoff to see if she had been given the tools she needed to do her job.

144. Dayhoff felt uncomfortable and intimidated in the meeting. She felt too uncomfortable to speak up about the things that were confusing to her about her job. Reed-Scott felt uncomfortable during the meeting and that Shaw's conduct was intimidating.
145. At the end of the meeting, Shaw apologized if he had made anyone uncomfortable by having the meeting and stated how important it was that he handle these matters right away.
146. From that month forward, performed all of her work remotely from Denver. She felt intimidated by Shaw and unwelcome in Rifle.

Mike Walker's Work on Shaw's Vehicle

147. Mike Walker is an eight-year employee at Rifle. He started employment as a Custodian I and was promoted into a Maintenance position in 2003, reporting directly to Elkins. Walker was paid several dollars an hour less than the other Maintenance workers but feared Shaw so much that he never asked Shaw for a raise.
148. In October 2007, Elkins brought Walker into Shaw's office. Elkins asked Walker if he was willing to help Shaw work on a classic car at Shaw's home which would be a father and son project for Shaw. Shaw knew that Walker was a classic car expert who participated in car shows during his spare time.
149. Walker agreed. No terms were discussed. Walker saw this invitation as an opportunity to develop a friendship with Shaw, with whom he had formerly had no contact at work. In addition, Walker enjoyed working on classic cars and was happy to help Shaw develop a project with his son.
150. Walker started going to Shaw's home once a week to help with a 1955 Cadillac. Soon, the project turned into a "full blown rebuild" of the car and Walker was at Shaw's house on both days off every week.
151. One Saturday Walker did not feel like going to Shaw's house to work on the car and he stayed home. The next day, Shaw was upset and confronted Walker by stating, "Where were you? I was waiting for you."
152. Walker never missed a day after that. He felt pressured to devote all of his non-working hours to the car. Walker feared that Shaw would fire him for not working on the car at Shaw's house during all of his free time.
153. Walker spent most of the time working on Shaw's car either alone or with Walker's own son.

Walker's Use of Paid Leave to Work on Shaw's Vehicle

154. Shaw stated to Walker, "You've got lots of leave, so you can use some to work on my car." Shaw stated to Elkins, "Mike's got lots of leave and he can use it to work on the car if it's okay with you."
155. Shaw also stated to Walker that he had a lot of annual leave saved up and he could use it to take a trip to pick up car parts for Shaw out of state.
156. Walker often worked at Shaw's home on the car on days he was scheduled to work. Walker used accrued paid annual and sick leave in order to complete the car project for Shaw.
157. On October 4 and 7, 2007, Walker used 9.5 hours of annual leave to work on Shaw's car. The "State of Colorado Leave/Absence Request and Authorization" form (leave slip) was signed by Elkins.
158. On October 14, 15, and 16, 2007, Walker used 9.25 hours of annual leave to work on Shaw's car. Elkins signed the leave slip.
159. On October 21, 25, and 28, 2007, Walker used 24 hours of annual leave to work on Shaw's car. Elkins signed the leave slip.
160. On December 9, 2007, Walker used 8 hours of annual leave, and on December 13, 2007, Walker used 8 hours of Governor's Holiday leave, to work on Shaw's car. Elkins signed the leave slip.
161. Elkins suffered a heart attack in December 2007. On December 19, 2007, Elkins went on Family Medical Leave Act (FMLA) leave for three months.
162. Walker started to feel uncomfortable using so much of his accrued annual leave to work on Shaw's car. Therefore, he started using sick leave for that purpose, with Shaw's approval.
163. On December 30 and 31, 2007, Complainant used 13.5 hours of sick leave to work on Shaw's car. Shaw signed the leave slip.
164. On January 10, 2008, Walker used 8 hours of annual leave to work on Shaw's car. Shaw signed the leave slip.
165. On January 13 and 14, 2008, Walker used 16 hours of annual leave to work on Shaw's car. Shaw signed the leave slip.
166. On January 20, 24, and 27, 2008, Walker used 24 hours of annual leave to work on Shaw's car. Shaw signed the leave slip.

167. On February 3 and 7, 2008, Walker used 16 hours of annual leave to work on Shaw's car. Shaw signed the leave slip.
168. Shaw planned to take the Cadillac being rebuilt by Walker to Moab, Utah, in April 2008 for a car show. The work on the car became more intense during the period leading up to the car show.
169. On March 2, 3, and 6, 2008, Walker used 22 hours of sick leave to work on Shaw's car. Shaw signed the leave slip, checking the box for sick leave.
170. On March 9, 10, 11, 12, and 13, Walker used 40 hours of leave time to travel to Tennessee, Ohio, and Illinois to pick up car parts for Shaw. Walker drove Shaw's truck and trailer. Shaw paid all expenses for the trip. Walker and his wife used a day or two of this trip for vacation time. On the leave slip, Walker stated, "please use my holidays." Shaw signed the leave slip on March 4, 2008, checking the box for "FML – holiday." The purpose of the paid leave was not related to FML – holiday leave.
171. On March 16 and 23, 2008, Walker used 16 hours of sick leave to work on Shaw's car. Shaw signed the leave slip, checking the box for sick leave.
172. On April 9, 10, 13, and 17, 2008, Walker used 32 hours of annual leave to work on Shaw's car. Elkins had returned to work and he signed the leave slip.
173. On April 20, 2008, Walker used 8 hours of annual leave to work on Shaw's car. Elkins signed the leave slip.
174. In all of the above instances, Shaw was aware that Walker was not sick but was instead working on his car.
175. On April 21, 2008, Walker attended the car show with Shaw in Moab, Utah. At that time, the Cadillac was worth approximately \$50,000.
176. In addition to the multi-state trip in early March 2008, Walker took three or four other trips out of state during the period October 2007 through April 2008, in order to purchase car parts for Shaw. Walker and his wife often stayed with relatives. The last trip was to Branson, Missouri with his wife, which was part vacation, paid for by Shaw.
177. During the period Walker worked on Shaw's car, Shaw gave Walker a \$2000.00 loan for a car, paid back by Walker, and two trucks. Walker gave one of the trucks to a friend; the other went to Walker's son, who also spent time at Shaw's home working on Shaw's car. Shaw also gave Walker a welder.

178. After the April 2008 car show in Utah, Shaw asked Walker to work on another car. Walker said no. Shaw stopped talking to Walker. Walker was disappointed because he had thought they were friends.

On-Call Pay to Walker

179. Walker's Structural Trades I position is not designated as a class eligible for on-call pay on the annual compensation plan.
180. Elkins's job classification as Physical Plant Manager, Structural Trades II, was subject to being on-call 24 hours a day for no extra pay. Elkins performed all after-hours maintenance work on an on-call basis for no extra pay at Rifle. Elkins lived in Rifle and was only called to Rifle by the nursing staff after normal working hours sporadically, usually once or twice a month.
181. In December 2007, Walker assumed the on-call duties for Elkins during his FMLA leave and was paid an extra \$2.00 an hour for it. In early 2008, because Walker had done such a great job filling in for Elkins, John Johnson, Shaw's supervisor, sent Shaw an email directing Shaw to give Walker a raise. Shaw showed Walker the email.
182. Shaw informed Walker that he was six months short of the experience requirement to be promoted to a Structural Trades II. He had discussions with Walker about paying Walker the on-call rate not only during, but also after Elkins' return to work.
183. Shaw knew that designation of an employee for on-call status must be performed in writing by an appointing authority. For example, on April 20, 2006, Shaw, Zaringo, Johnson, and one other individual, signed an "On Call Pay" memo granting written permission to three Rifle nurses to receive on-call pay.
184. In January 2008, Shaw handed Walker a stack of blank on-call leave slips, and told him to fill them out and when they were full, hand them back to Shaw. The express or implied implication was that the on-call pay would be Walker's "raise" for the next six months.
185. Shaw told Walker not to tell anyone about the arrangement to pay him on-call pay.
186. Shaw ordered Lisa Scott-Reed, Payroll Officer for Rifle, to fax the on-call timesheets submitted by Walker and signed by Shaw to the Western District payroll office. She did so.
187. Shaw did not issue a written designation for Walker to be eligible for on-call pay and maintained no record of an on-call designation for Walker.

188. Customarily, Elkins signed all of Walker's leave request slips as his supervisor. Shaw signed the on-call sheets.
189. Elkins returned to work full-time at Rifle on March 19, 2008, when he was released by his doctor to work with no restrictions. Shaw sought to assist Elkins in regaining full health by using Walker for on-call work. He refrained from using Elkins for on-call work after hours and also attempted to minimize the heavy lifting Elkins performed on the job.
190. Shaw continued to sign Walker's on-call timesheets after Elkins' return from FMLA leave and did not disclose the arrangement to Elkins.
191. On March 20, 2008, Shaw received the approval from HR to promote Walker to Structural Trades II. Shaw did not sign the paperwork or process it. Shaw was aware that Walker was spending his free time at Shaw's home working on his vehicle and using paid annual and sick leave to do so at that time.
192. Walker entered every hour of every day that he was not at work on the on-call sheets. He entered 24 hours for days he did not work, and he entered 24 hours minus the time he was at work for the days he was at Rifle. Shaw signed them all and submitted them to Reed-Scott for processing.
193. Walker submitted on-call timesheets as follows: 305 hours in January 2008; 605 hours for February 2008; 458.50 hours in March 2008; 607.25 hours for April 2008; 578.50 hours for May 2008; 488.25 hours for June 2008; 541.25 hours for July 2008; and 507.75 hours for August 2008.
194. Between January and July or August 2008, Walker was paid \$7290.00 in on-call pay. He performed on-call work for Rifle on a sporadic basis during that period, once or twice a month.

2008 Survey and Root Cause Analysis

195. On April 4, 2008, the annual state survey of Rifle resulted in fourteen deficiencies or tags, which are violations of the federal regulations governing long term care facilities in the United States. Several of the deficiencies were "G level," meaning that the violations resulted in actual harm. The prior year, Rifle had received only three tags. Because of the dramatic increase in tags, the Office of State and Veterans Nursing Homes retained an independent research firm to conduct a root cause analysis of Rifle. The scope of the report was to assess Rifle's operational ability to provide quality of care and quality of life to residents and the potential impact on survey readiness.
196. The Root Cause Analysis, an extremely well researched and documented report, was published on June 3, 2008. The report identified and reported overall strengths and weaknesses at Rifle, and made recommendations for an action

plan. The report concluded that both external and internal factors contributed to problems at Rifle. External factors included the fast-paced economic development in and around Rifle in Garfield County, due in large part to oil shale development. This had caused a construction and population boom, resulting in labor shortages and extremely high housing costs. Competition for labor in the health care arena was tight. In addition, the national professional nursing labor shortage also adversely affected the labor pool in Rifle.

197. The internal factor consisted of the negative work climate at Rifle, which led to higher than average turnover rates. Exit interviews with former employees showed that 47% stated that management, including retaliation or fear of retaliation, was a reason for separation from employment; 32% cited favoritism.
198. Interviews with current employees revealed that staff were overworked, burned out, and unmotivated; many had issues with management; and many felt favoritism by management, and that management doesn't keep promises (primarily pay, vacation or training orientation).
199. According to the report, among current employees, "The NHA was very frequently described as 'smart, 'intimidating', 'angry', 'controlling'."
200. The report summary concluded, "Staffing turnover and shortages appear to be symptoms of both internal management and operational issues as well as external shifts in the economy and housing. . . In effect, in terms of an organizational life cycle framework, this organization is in decline and requires a turnaround. . . Effective turnarounds require, at a minimum, an acknowledgement by the organization of the internal causes and contributors to problems (and not just being 'victimized' by external factors), managerial and operational competence and finally, a commitment to change behavior."

August 2008 Manley Visit to Rifle

201. After the poor April 2008 survey results in Rifle, a state legislator from the Rifle district contacted Manley to arrange a site visit at the facility.
202. In August 2008 Manley visited Rifle with the state representative. During that visit she was informed by an anonymous employee who whispered in her ear that several employees sought to speak with her but were afraid to do so.
203. Manley distributed her cards at the facility and invited Rifle staff to call her any time.
204. The week after Manley's visit, Ken Henderson called her. Henderson had left Rifle by that time. He informed Manley about the experience at Aurora South with patient FB. Manley asked Henderson if he could corroborate his report, and

he said that he could, referring her to Brian Crowe. Crowe also had left Rifle by this time.

205. On September 5, 2008, Manley spoke by telephone with Brian Crowe. They discussed the FB incident and Crowe informed her that he had sent a letter previously regarding the incident. Manley obtained that letter and asked Crowe to put his concerns in writing. Crowe went to the 21st Judicial District Attorney's Office and on September 15, 2008, swore out an affidavit summarizing the October 12, 2007 trip with FB. The affidavit states in part, "Susan Zarlingo further instructed us to leave the hospital immediately after 'dumping' Mr. B without providing any information regarding us, our agency or Mr. B."
206. On September 18, 2008, Manley received a letter from Kenneth Henderson also describing the FB incident. He stated in part, "My orders from the DON were to deliver the resident and leave. The staff at this center stated that I could not leave the resident with them. I called my DON for instructions three times. I was made very uncomfortable, embarrassed, and felt that I had committed a crime by leaving him. The hospital staff stated that I could not abandon this resident. When I called the DON for support because I was scared, she stated that I was to follow instructions, 'get the hell out of there Ken!' and 'you didn't use my name did you?' and 'this is how the system works.' I literally had to sneak into another room, hide, and run out to the state car. I was accompanied on this trip by a member of the maintenance department at [Rifle]. Neither one of us had received training in managing aggressive, violent and unpredictable men."

Administrative Leave with Pay for Shaw and Zarlingo; Manley Initiates Investigations

207. On September 22, 2008, Manley placed Shaw and Zarlingo on paid administrative leave pending the investigation of the patient dumping allegation.
208. Manley immediately assigned Lori Seim to be the Acting NHA at Rifle.
209. Manley spoke to HR staff regarding the issues that had been raised regarding the management style of Shaw and Zarlingo. HR suggested that Manley retain Mountain States Employers Council (MSEC) to conduct an independent investigation into the workplace environment at Rifle. Manley retained MSEC to investigate the Rifle work environment.
210. Manley assigned Janet Dauman, Director of Quality Management in Manley's Office, to investigate the FB patient neglect/abandonment issue. In addition, Manley directed another nursing expert to conduct a chart review of FB's medical record at Rifle.
211. Brian Crowe had also raised an allegation with Manley regarding a fraudulent insurance claim for air conditioning units at Rifle. Manley directed Seim to

investigate the facts concerning the lightning strike, whether the air conditioning units had been damaged, and whether a fraudulent insurance claim had been filed.

Seim Investigation of Insurance Fraud

212. After Seim became the Acting NHA at Rifle, she conducted her investigation. She interviewed Elkins and Ledbetter, who provided her with all written documentation in connection with the insurance claim. After confirming that eleven AC units had been purchased and delivered to Rifle, Seim made an appointment to tour the Rifle facility to examine the new AC units with Elkins.
213. Elkins informed Seim that former employee Crowe had installed one of the new AC units in the Rifle facility, and that some of the damaged AC units in the Rifle facility had been repaired and were functioning. Therefore, not all of the new units had been installed.
214. After her interview of Elkins, Seim toured the Rifle property. Seim visited the storage shed and confirmed with her own eyes that ten of the new AC units purchased from DWG in August 2007 with the insurance proceeds were still in their shipping boxes, stored on the Rifle property.
215. Seim did not interview Shaw in relation to the insurance fraud issue because she knew that he was on paid administrative leave pending the investigations. Her understanding was that she was prohibited from doing so.
216. Manley also directed a third party electrician to assess the actual damage to the air conditioning units at Rifle.
217. Seim wrote a summary of her investigation and submitted her report to Manley.
218. Manley determined that because there may have been actual fraud as defined by DHS's fraud policy, it was necessary to have the Audit Division of DHS conduct an investigation of the insurance fraud issue.
219. Manley contacted Charissa Hammer, Director of the Audit Division at DHS, and requested a full internal investigation into the insurance claims for air conditioning units at Rifle.
220. At the time Manley asked Hammer to conduct the internal investigation into potential insurance fraud at Rifle, Manley had no idea that Hammer's investigation might lead to a criminal charge against Shaw.
221. In the meantime, less than one month after Seim became Acting NHA at Rifle, Seim went on annual leave. During her absence, her temporary replacement, Scott Bell, discovered an on-call timesheet for 350 hours for Walker for August

2008. Scott questioned the legitimacy of the hours and forwarded it to other staff.
222. On October 29, 2008, Seim returned from vacation to find the on-call timesheet and a note from Margie Maynard, the Acting Director of Nursing (ADON). Maynard indicated that Elkins was the on-call maintenance worker and she was unfamiliar with any arrangements for Walker to do on-call work.
223. Seim brought the Walker on-call sheet to payroll clerk Reed-Scott, who confirmed that Walker had received on-call time sheets from January through August 2008 and that Shaw had signed all of them. Seim requested that Reed-Scott bring her all of the on-call timesheets so she could understand the full situation.
224. Seim informed Manley of the on-call arrangement. Manley directed Seim to investigate the facts surrounding Shaw's approval of on-call pay for Walker.
225. Seim conducted a thorough investigation. The results were such that Manley again referred it to Hammer in the Audit Division for an investigation into whether fraud had occurred.

Hammer Investigations of Insurance Fraud and Use of On-Call and Leave for Walker

226. Hammer, a Certified Public Accountant and Certified Fraud Examiner, is responsible for monitoring DHS's use of federal and state funds, conducting compliance audits and internal investigations, and for providing technical assistance on federal and state rules.
227. When Hammer receives an allegation of fraud, she screens and reviews the allegations, collects evidence, determines whether there is intent for criminal fraud, and if so, prepares the case for referral for prosecution. Hammer works closely with the District Attorney offices in various districts as part of her job.
228. Hammer commenced her investigation of the insurance fraud and leave abuse issues in November 2008. Hammer and her assistant obtained and examined all payroll records for Walker, including but not limited to Kronos reports, pay stubs, leave request forms, and on-call sheets.
229. Hammer also interviewed Ledbetter, who confirmed that he had only seen one damaged AC unit on his visit to Rifle.
230. In mid-December 2008, Hammer and her assistant traveled to Rifle. They inventoried all of the AC units at Rifle, including the ones Elkins had listed on the Lenny's invoice as having been damaged by the lightning storm. They also inventoried the new units in unopened boxes. Upon their return to Denver,

Hammer used serial numbers to confirm that the AC units purchased with insurance proceeds were the units in unopened boxes in the shed in Rifle.

231. Hammer interviewed five Rifle employees, including Walker, Elkins, Reed-Scott, and two nurses that worked the night shift during the period Walker received on-call pay. The night nurses indicated that Walker had been contacted for on-call work after hours on a sporadic basis.
232. Hammer asked Walker to examine all of his leave slips and write on them the times he worked on Shaw's vehicle. Walker complied with this request.
233. Hammer then interviewed Crowe regarding the AC units and he confirmed one had been damaged and that he had informed Shaw and Elkins of this fact.
234. Hammer did not attempt to interview Shaw in the course of conducting her investigation. The last time she had conducted an investigation involving Shaw he had refused to meet with her. Also, Hammer knew that he was on paid administrative leave for the duration of the investigation.
235. Hammer concluded that Shaw had engaged in fraud in filing the insurance claim for eleven AC units and that he had misappropriated state funds by paying Walker on-call pay and approving his paid sick leave to work on his personal vehicle.
236. Hammer drafted an Economic Crime Complaint Form with her report attached. Also attached were all documents she reviewed and transcripts or notes from all interviews conducted. The report is 229 pages in length. She filed it with the Denver District Attorney's Office and gave it to Manley.

Dauman Investigation of FB Transfer and Discharge

237. Dauman, Director of Quality Management for the Office of State and Veterans Nursing Homes, assures compliance with state and federal regulations governing long term care facilities in Colorado. She is responsible for the oversight of all clinical care provided in the nursing homes under the Office's jurisdiction, including Rifle.
238. Manley directed Dauman to investigate the FB incident. Dauman reviewed the Crowe affidavit and letter, the Henderson letter, the entire medical record for FB at Rifle, and parts of the medical record for FB at Aurora South. She interviewed Henderson, Crowe, Dr. Dublin, and every Rifle staff person who charted in FB's medical record. In the course of conducting a computer review of all files on FB at Rifle, Dauman discovered the notes Barbara Kennedy had written on October 17, 2007 concerning her conversations with Shaw and Zarlino about FB.

239. Dauman concluded that the discharge of FB did not follow facility policy or usual practice because the resident was taken to Denver instead of Grand Junction or the hospital in Rifle. In addition, she found violations of federal regulations and Rifle policy because no written notice of discharge was given to FB or his MDPOA prior, at the time of, or after his release from Rifle. Untrained personnel transported FB to Denver in the back seat of a state car. Because FB had recently been aggressive and unpredictable, the mode of transport risked an adverse occurrence during transportation.
240. Dauman's investigation supports the conclusion that Shaw and Zarlingo engaged in patient abandonment on October 12, 2007. Her interview of Dr. Dublin contains the doctor's opinion that FB was "dumped" at Aurora South by Rifle. Dauman and two nursing experts who performed chart reviews for her investigation found no mention of a bed hold for FB in his chart at Rifle.
241. Dauman's investigative report is six pages in length, with attachments of all documents reviewed and interview transcripts, for a total of 140 pages. She forwarded her report with attachments to Manley.

MSEC Investigation

242. Jody Luna, an attorney at MSEC, conducted the investigation of the workplace environment at Rifle. Luna is a former public defender, magistrate, staff attorney for the Colorado Supreme Court Grievance Committee, and HR and compliance attorney for Anthem Blue Cross.
243. Luna conducted interviews of twenty-five Rifle employees. Eight of those she chose randomly, in order to obtain a representative sample of disinterested employees. She also interviewed current and former Rifle staff who had registered complaints about Shaw and Zarlingo, including Crowe and Henderson.
244. Luna spent an entire day interviewing Shaw and Zarlingo, with their attorney present.
245. Luna takes contemporaneous notes on her computer when she conducts interviews. Immediately following the interview, she asks the individual to read her notes, make changes to assure accuracy, and then sign the statement and date it. Luna modified this process for Shaw and Zarlingo by permitting them to take their statements with them, make changes, and return the signed statements at a later date.
246. Luna determined that many of the accusations against Shaw were not true and were rumors generated by his absence and general withdrawal from staff at the facility.

247. Luna also concluded that Shaw rarely interacted with staff, kept his door closed at all times, and that some employees justifiably perceived him as "intimidating." She also concluded that Shaw had gotten angry with Lori Seim during his April 2008 meeting with her.
248. Luna further concluded that Zarlingo has told staff members that they are replaceable, occasionally raises her voice to staff members, rarely interacts with employees, and was dismissive and unapproachable to many staff.
249. Seim noted that Shaw acknowledged having received complaints about Coppock and Zarlingo and that other than speaking to them, he had done nothing to change their supervisory style.
250. Luna wrote a 64-page report and attached the witness statements to it. She forwarded it to Manley.

Pre-disciplinary Process

251. Manley read all of the investigative reports, including the attachments.
252. On December 11, 2008, Manley sent letters to Shaw and Zarlingo, providing notice of a pre-disciplinary meeting, on a December date of their choice. Manley copied their attorney, Ms. Cookson. The letter to Shaw noted that the following issues would be addressed at the meeting: assigning state employees under his direct span of control to perform maintenance on his private vehicles and personal property; dumping resident FB, who was under Shaw's protection as the NHA, at Aurora South Hospital; engaging in workplace violence, harassment, and/or intimidation of staff under his span of control; and fraud as it relates to state property (air conditioners) and the filing of a fraudulent insurance claim. Zarlingo's letter addressed the patient dumping of FB and alleged violence, harassment, and/or intimidation of staff under her supervision.
253. On December 16, 2008, Manley sent to Complainants' counsel copies of all investigative reports upon which she would rely in making her decision. On January 5, 2009, Manley had the reports sent via Federal Express.
254. Manley extended the Complainants' paid administrative leave until such time as the pre-disciplinary process was completed and she had made a decision.
255. Hammer completed her investigative report on January 8, 2009. As soon as Manley received it, she sent it to Complainants' attorney as an attachment to an email. At the time it was sent, Complainants and their attorney were on their way to Denver to meet with Manley for the pre-disciplinary meetings.
256. Correspondence ensued between Manley and Complainants' counsel, regarding several requests for additional time to prepare for the meeting, and Manley's

agreement to extensions. Zarlingo became ill, prompting one postponement, and Shaw then became ill, prompting another postponement. Doctors' notes were provided to Manley to confirm their illness. The meetings were re-scheduled two more times.

257. On January 21, 2008, Complainants and their counsel each attended individual pre-disciplinary meetings with Manley and HR Director Mary Young. At both meetings, Ms. Cookson stated that until the Complainants had met with a criminal defense attorney, they would invoke their 5th Amendment right not to incriminate themselves and would therefore not speak at the meetings. Ms. Cookson asked for another extension of time to hold the pre-disciplinary meetings until after they had met with criminal defense counsel.
258. Manley responded that it would not be possible to postpone the pre-disciplinary process further. However, Manley agreed as a compromise to utilize a written pre-disciplinary process under State Personnel Board Rule 6-10(a), under which she would send a letter to Complainants stating the grounds for potential discipline. Manley would then provide Complainants with fifteen days to respond in writing.
259. At the meetings, Complainants' counsel informed Manley that she should refer to the June 2008 Root Cause Analysis as mitigating information to consider. Manley agreed to do so.
260. On January 26, 2008, Manley sent a "Rule 6-10(a) letter" to Shaw, attaching the Root Cause Analysis for his review. The four-page letter outlined specific information on each of the four incidents that would provide the basis for potential disciplinary action. It also referenced the investigative reports she would rely on, previously sent to Complainants and their attorney.
261. In addition to the letter, Manley sent an "Attachment A." This document is an extremely detailed, eight-page set of questions for Shaw to answer. These questions provided Shaw with the opportunity to provide a focused response and detailed mitigating information to Manley for her consideration.
262. Under the "Electrical and Insurance" section, Manley listed seventeen questions, including: what was his version of what happened immediately following the lightning strike, particularly regarding the AC units; explain what parts of the investigative report and Audit Division Complaint he disagreed with and provide detailed explanations of his position; what was his relationship with Lennie Goodman; did Goodman provide the blank invoice to him or another Rifle employee; who made the determination that twelve AC units had been damaged in the lightning strike; as NHA and signing authority, did he verify the insurance claim for replacement of twelve units despite his knowledge that only one unit was damaged; if not, why not; was he aware that Brian Crowe had repaired all of

the units for approximately \$2000; if any of the AC units were truly damaged, why were 9 units still not installed almost one year after the storm.

263. Regarding the Mike Walker leave abuse and on-call pay abuse issue, Manley posed eighteen questions, including: respond to the Hammer report and give his side of the story regarding on-call pay and annual and sick leave for Walker; explain why he placed Walker on on-call pay; did he ever discuss with HR his decision to place Walker on on-call pay; did he follow proper protocol to place Walker on on-call status and why did he not use the same written memorandum process Shaw had used on April 20, 2006, attached; how did he justify the on-call pay after Elkins returned from FMLA with no restrictions; did he place Walker on on-call status to compensate Walker to restoring Shaw's vehicle; how did he compensate Walker for expense and time for travel for purchasing vehicle parts; why did Shaw approve Walker's sick, annual, and on-call leave instead of Elkins, his direct supervisor; did he instruct Walker that he could use annual and/or sick leave so he could work on Shaw's car or make trips to buy parts for his car; why didn't Shaw sign the referral for Walker's promotion on March 20, 2008, when he received it from HR; Walker stated multiple times he feared he would be fired if he did not work on Shaw's car, please respond.
264. Manley asked over twenty questions regarding the issue of "Employee Communication," most of them based on specific findings in the MSEC report. She asked Shaw to respond to the report generally, and also asked: how much time did Shaw spend making rounds in the home interacting with residents and staff; how did he respond to employee statements that Shaw was not around; how did he respond to three specific employee statements that they feared retaliation from Shaw and the Root Cause Analysis Exit Survey data that 47% of employees who left listed as a reason "management (including fear of retaliation"; why had Shaw not followed Manley's directive to deal with complaints about Coppock's communication problems; why did 32% of former employees list "favoritism" as a reason for leaving; did he feel he treated all staff equally.
265. Finally, Manley posed twenty-seven questions to Shaw on the issue of FB's transfer and discharge. The questions focused on the federal regulations and Rifle policies governing transfers and discharges, and Shaw's responsibility as NHA for enforcement of those policies. Manley also asked Shaw: did he agree with the investigative report and if not, what portions were inaccurate and provide his version of events; did he recall a conversation with Barbara Kennedy regarding FB's discharge; did Shaw refuse to speak with the West Pines case manager about the return of FB to Rifle.
266. On February 3, 2008, Manley emailed several DHS policies and procedures to Complainants' counsel.
267. On February 7, 2008, Shaw responded to Manley's January 26, 2008 Rule 6-10(a) letter. His letter contained no answers to Manley's questions. Shaw's

responses to the substantive questions on the four areas of potential disciplinary action consisted of questions, not answers. Shaw requested that Manley interview several individuals and provided questions for her to ask them. Shaw asked Manley to review his performance evaluations. He reiterated his request for another ten day extension of time. Lastly, Shaw invoked his 5th Amendment right against self incrimination in connection with each of the four areas of potential discipline.

268. On January 26, 2008, Manley sent a Rule 6-10(a) letter to Zarlingo addressing the two issues of patient neglect/abandonment of FB and workplace violence, harassment and/or intimidation of Rifle staff. The letter contained an attachment with detailed questions, analogous to that sent to Shaw. With regard to FB, Manley asked: did Zarlingo agree with the investigative report regarding FB and if not, explain the portions that were inaccurate and provide her version of what occurred; did Zarlingo inform Ms. Kennedy that “she would be asking for trouble personally” if she contacted the Ombudsman; did Zarlingo order staff to deliver FB to Aurora South and then leave; did Henderson call her from Aurora South; what did she recall about the conversation; did she make the statements Henderson alleged in his letter to Manley; as the DON responsible for medical treatment of residents, was FB provided medically appropriate care when transported in a car instead of an ambulance. In addition, the letter attached the Root Cause Analysis.
269. On February 7, 2008, Zarlingo sent her response letter to Manley, which also contained no answers to Manley’s questions. Zarlingo posed questions to Manley and requested that she interview many witnesses, providing questions for her to ask. Regarding FB, Zarlingo asked Manley to review the Senior Care medical file for FB, Rifle police department records concerning FB during October 2007, all telephone records and telephone message pad records concerning FB from Rifle, Senior Care, and Aurora South, all email records concerning FB from the same facilities, all expense reimbursement forms submitted by Crowe and Henderson for their trip to Aurora South, and all telephone records from Crowe and Henderson’s communications with Zarlingo, Aurora South, and Rifle, on October 12 and 13, 2007. Zarlingo invoked her 5th Amendment right against self incrimination.
270. Manley reviewed the response letters of Shaw and Zarlingo and contacted nearly every witness she had been requested to contact. She asked the questions as requested. Manley also reviewed all of the documents Shaw and Zarlingo requested.
271. Manley reviewed the personnel files of Shaw and Zarlingo, including their performance evaluations. She noted that neither of them had ever received a corrective or disciplinary action during their tenure at Rifle.

272. Manley concluded that the misconduct of Shaw and Zarlingo was so serious that termination was the only appropriate decision.

Termination Letters

273. On February 20, 2008, Manley sent termination letters to Shaw and Zarlingo. In each letter, she noted the fact that neither of them provided mitigating information for her to consider. Manley reviewed the lists of individuals Complainants had requested that she interview, outlined those she had spoken with, and provided the results of those interviews. She also listed all documents Complainants had requested that she review, and noted her findings based on that review.
274. Manley concluded that Shaw had assigned Walker to perform maintenance on his private vehicle and personal property, inappropriately paid Walker \$7290 in unauthorized on-call compensation as pay for working on his personal vehicle, secretly assumed signature authority for Walker, and authorized 178 hours of annual and sick leave to work on his personal vehicle. Manley also concluded that Walker was fearful of retaliation by Shaw if the car was not completed by Shaw's deadline. Manley found that Shaw had violated the DHS Code of Conduct, Fraud Prevention Policy, Ownership and Use of State Assets Policy, Workplace Violence Policy, State Personnel Board Rule 3-46 governing on-call pay, and Board Rule 1-16.
275. Manley also concluded that Shaw had committed client abuse/abandonment of resident FB, who was under Shaw's protection as the NHA of the facility. Manley noted that at his request, she had reviewed telephone records which revealed that West Pines staff had called several times and urgently wanted to speak with him. She also reviewed the police report filed indicating that FB assaulted members of the Rifle nursing staff. She stated, "This indicated to me that the resident was unstable, vulnerable and required extra diligence with care and potential transfer to another setting." Manley concluded that the transfer of FB was not in accordance with applicable policy, statute or regulation, and that FB was not re-admitted to the facility as required by policy and regulations nor was his power of attorney timely notified of her rights regarding FB's removal. Manley found that Shaw had violated federal regulations and Rifle's policy governing discharges and transfers. Manley determined that Shaw had retaliated against Crowe for coming forward by intimidating him into resigning, in violation of the workplace violence policy.
276. Manley found that Shaw had been absent as a manager and was perceived as intimidating, retaliatory, and angry by many staff, in violation of the Workplace Environment Policy, Employee Code of Conduct, Workplace Violence Policy, and Governor Romer's Executive Order governing Workplace Violence.
277. Lastly, Manley found that Shaw had engaged in insurance fraud by permitting the claim for replacement of AC units to be processed, when he knew that only one

unit had been damaged by lightning. She determined that Shaw violated the Fraud Prevention Policy, Ownership and Use of State Assets Policy, and DHS Code of Conduct.

278. Manley terminated Zarlingo for client abuse/abandonment of FB and for violations of the same regulations and policies as Shaw. In addition, Manley concluded that Zarlingo had engaged in workplace violence, harassment, and/or intimidation of staff under her span of control. She found that Zarlingo had violated the Employee Code of Conduct, Workplace Environment Policy, Workplace Violence Policy, and the Executive Order governing workplace violence.
279. On April 29, 2009, a Grand Jury in Denver presented an indictment for two counts of felony theft and one count of misdemeanor first degree official misconduct against Mr. Shaw, in relation to his use of a state employee to perform maintenance on his private vehicle, and payment of the employee with purportedly unauthorized on-call pay. Ms. Zarlingo is mentioned at least twice in the indictment.
280. Neither Shaw nor Zarlingo testified at hearing.
281. Complainants timely appealed the disciplinary action.

DISCUSSION

I. GENERAL

Certified state employees have a property interest in their positions and may only be disciplined for just cause. Colo. Const. Art. 12, §§ 13-15; §§ 24-50-101, *et seq.*, C.R.S.; *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994). Such cause is outlined in State Personnel Board Rule 6-12, 4 CCR 801, and generally includes:

- (1) failure to perform competently;
- (2) willful misconduct or violation of these or department rules or law that affect the ability to perform the job;
- (3) false statements of fact during the application process for a state position;
- (4) willful failure to perform, including failure to plan or evaluate performance in a timely manner, or inability to perform; and
- (5) final conviction of a felony or any other offense involving moral turpitude that adversely affects the employee's ability to perform or may have an adverse effect on the department if the employment is continued.

In this *de novo* disciplinary proceeding, the agency has the burden to prove by preponderant evidence that the acts or omissions on which the discipline was based occurred and that just cause warranted the discipline imposed. *Department of Institutions v. Kinchen*, 886 P.2d 700 (Colo. 1994). The Board may reverse or modify

Respondent's decision if the action is found to be arbitrary, capricious or contrary to rule or law. Section 24-50-103(6), C.R.S.

II. HEARING ISSUES

A. No inference is made against Complainants based on their failure to testify.

It is permissible to draw a negative inference against both Complainants based on their failure to testify at hearing. *Asplin v. Mueller*, 687 P.2d 1329, 1332 (Colo.App. 1984). However, under the limited circumstances of this case, it is concluded that such an inference would not be appropriate. Several investigations were conducted in this case in which Complainants were not interviewed. Therefore, Complainants' side of the story and their mitigating information was not integrated into those investigations.

Manley expected to address this information deficit through the pre-disciplinary process. In an effort to assure that the pre-disciplinary process was a full and fair exchange of all information upon which discipline might be based, Manley sent Complainants full sets of all investigative reports prior to the pre-disciplinary meetings. Then, unbeknownst to Manley, Hammer prepared an Economic Crime Complaint Form and sent it to the District Attorney's office on the day Manley planned to conduct the pre-disciplinary meetings with Complainants. This dramatic turn of events resulted in a modified pre-disciplinary process. These circumstances render it unjust to draw a negative inference against Complainants based on their failure to testify.

B. Complainants committed the acts for which they were disciplined.

Shaw. Respondent has proven by preponderant evidence that Shaw committed the acts for which he was disciplined.

With regard to the on-call pay issue, Shaw knew that on-call pay was required to be approved in writing by the appointing authority and was to be utilized only when necessary for the benefit of the State. In addition, Shaw was aware that Walker was spending all of his non-working hours at Shaw's home working on Shaw's personal vehicle during the time he was being paid on-call wages. As Administrator for Rifle, Shaw knew that Elkins performed on-call work at no cost to the facility, and that Elkins was called to the facility only once or twice a month on a sporadic basis. Yet the number of on-call hours Shaw approved for Walker was in the hundreds every month. Shaw paid Walker on-call wages in the amount of \$7290, almost all of which was fraudulent (the exception being a few hours during the three months Elkins was on FMLA leave). As a self-funded facility, Rifle, and its residents, suffered a commensurate loss of those funds. Shaw violated his fiduciary duty to Rifle and DHS and, in turn, the DHS Prevention of Fraud policy.

Shaw was given clearance to promote Walker to the Structural Trades II position on March 20, 2007. However, he opted not to sign the paperwork. Instead, he continued to utilize a secret arrangement to pay Walker which he could terminate at will.

This arrangement permitted Shaw to maintain inappropriate control over Walker through the end of the summer of 2008.

Regarding Walker's use of paid annual and sick leave to work on Shaw's car, Shaw made it clear to Walker that failure to work on his personal vehicle was unacceptable. Shaw expressed anger towards Walker if he failed to work on his vehicle. Shaw then suggested to Walker that he utilize his own accrued annual and sick leave to work on the vehicle instead of showing up for work at Rifle. Shaw directly caused Walker to engage in fraudulent abuse of sick leave. Aware that Walker had used sick leave to either work on Shaw's car, or to travel to another state to obtain car parts for Shaw's benefit, Shaw then signed Walker's leave forms approving the paid sick leave on multiple occasions.

Shaw utilized state resources in the form of paid sick leave to pay Walker to perform work exclusively for Shaw's personal benefit. This flagrant breach of Shaw's fiduciary duty to Rifle and DHS violated DHS's Fraud Prevention Policy and the Ownership and Use of State Assets Policy.

With regard to the insurance claim for eleven air conditioning units at Rifle, Shaw knew that only one unit had actually been damaged by lightning. Crowe informed Shaw and Elkins of this fact. In addition, on July 19, 2007, Ledbetter informed Shaw in an email that Crowe indicated the AC units had not been damaged and directed Shaw to send pictures of all damaged units to support the insurance claim. Receiving no response, Ledbetter sent a second request for photos of the damaged units to Shaw on July 26, 2007. Shaw never did so and never directed staff to comply with this request. Instead, Shaw took himself out of the loop and directed Ledbetter to deal directly with Elkins, who also never provided photographs of damaged AC units. Shaw's direction to Ledbetter to deal exclusively with Elkins did not eliminate Shaw's duty as the fiscal agent for the Rifle facility to deal honestly with Ledbetter and the insurance company.

Shaw knowingly permitted an inaccurate insurance claim to be filed and accepted an insurance payment exceeding \$13,000 for units he knew not to be damaged by the lightning storm. As the NHA for the Rifle facility, it was Shaw's fiduciary duty to assure the accuracy of the insurance claim and protect state assets, which include insurance proceeds. It was also Shaw's duty to conduct financial business honestly. Shaw violated DHS's Fraud Prevention Policy by committing a dishonest act for the direct personal situational benefit of Shaw as NHA at Rifle. Shaw also violated the DHS Employee Code of Conduct, which requires all state employees to be truthful and honest to coworkers and customers at all times.

Respondent did not prove that Shaw retaliated against Crowe for raising a concern about the insurance fraud issue.

Turning to the FB incident, the Colorado regulations governing NHA's mandate that all NHA's assure compliance with all local, state, and federal laws and regulations; ensure and promote a quality of care and quality of life that is consistent with the health

and safety of the residents in the NHA's facility; protect resident rights, including protection against abuse, neglect, and other mistreatment; and foster effective communication and problem solving between management, staff, residents, family, community, and all parties involved to provide for residents' rights, health, safety, and welfare.

Shaw violated all of these regulatory mandates in his handling of the FB transfer and discharge. The evidence shows that despite a diagnosis of Alzheimer's disease and depression, FB was admitted to Rifle not on the secure Alzheimer's unit, but on the general population unit. Predictably, FB did not acclimate well to his new environment and, after a traumatic transition period, was moved to the secure unit. Once there, Shaw did not involve himself in FB's care and treatment or in the problem solving process of determining the best course of action for FB. Instead, Shaw treated FB as a problem to be resolved by his expulsion from the facility.

Once the physician's order was obtained to transfer FB to Aurora South, Shaw had a duty to assure compliance with federal regulations and Rifle policy requiring written notice to FB and his MDPOA. This written notice requires essential information governing Rifle's bed hold policy, the right to appeal and to contact the state's long term care Ombudsman, and other patient rights. Shaw violated this regulation and his own facility's transfer policy twice by failing to assure that written notice was given at the time FB was transferred to Aurora South and after Rifle determined it would not accept FB back at the facility. It is noted that in emergency transfer situations, the written notice may be given "as soon as practicable." Nevertheless, in this case, written notice was never given. Shaw also gave false assurances to Dr. Dublin that FB would be allowed to return to Rifle after he was stabilized.

In addition, Rifle's "Notice Before Transfer/Discharge" policy includes the provision, "The facility will provide sufficient preparation and orientation to the resident to ensure a safe and orderly transfer or discharge from the facility. This preparation may include assisting the resident and family in the selection of a new residence, communicating with the receiving facility regarding the care needs of the resident and reviewing the staff routines for handling a transfer and discharge with the resident and family to reduce unnecessary anxiety or depression." Shaw flagrantly violated this policy by failing to personally comply with it and by failing to direct his staff to comply prior to and following FB's transfer on October 12, 2008. No one from Rifle communicated with the receiving facilities regarding the care needs of FB; and, once contacted, Shaw personally refused to engage in such communication with either Aurora South or West Pines.

Shaw committed patient neglect and abandonment and violated federal regulations and Rifle policies governing discharges of long term care residents by refusing to hold FB's bed open for him and accept him back at Rifle once FB had been stabilized. On October 17, 2008, when West Pines informed Rifle staff that it was ready to transfer FB back to his home in Rifle, Shaw was required to accept him back. Shaw's

handling of FB's transfer and discharge constitutes a serious violation of his duty to care for residents under his protection as NHA.

Complainants argued at hearing that when Aurora South discharged FB to West Pines on October 13, 2007 for assessment and stabilization, this patient movement constituted a discharge of FB by Aurora South, thereby "triggering" Rifle's right to require FB to reapply for admission. However, no evidence in the record supports this strained reading of the federal regulations and Rifle's policies. If Rifle sought to discharge FB after he was stabilized, it was required by federal regulations and Rifle policy to accept him back on October 17, 2007, and then provide thirty days notice of its intent to permanently discharge him.

Manley also based her termination decision on Shaw's creation of a hostile work environment for staff under his authority. The preponderance of evidence demonstrates that Shaw had favorites, that most Rifle staff were too intimidated to talk to Shaw, and that Shaw rarely interacted with staff, many of whom did not know who he was. In addition, when staff approached Shaw to talk, he often responded by stating he was too busy. At Management Meetings, Shaw dismissed staff ideas and permitted Zarlingo to repeatedly inform the group that they were all replaceable. Walker was so afraid of Shaw that he spent all of his personal time, and a significant amount of paid sick and annual leave time, over a seven-month period, working on Shaw's personal vehicle. After Walker stayed home for one Saturday, Shaw's angry response was sufficient to convince Walker that Shaw would retaliate against him if he took another day off of the project.

Shaw was also aware of Kim Coppock's intimidating and harassing supervisory style towards those in the front office under her authority and did nothing about it. The problem was so serious that her supervisees did not know their job duties and went to Seim for assistance. When Seim brought the issue to Shaw's attention, he became angry with Seim and refused to discuss it. Then, he held a group meeting that accomplished nothing and was not conducive to an open exchange of information. This meeting demonstrated that Shaw would continue to condone Coppock's hostile and intimidating supervisory style.

Shaw personally created a hostile work environment at Rifle. In addition, by permitting Zarlingo and Coppock to engage in harassing and intimidating behavior towards their subordinates, Shaw permitted a hostile and intimidating work environment to persist under his authority.

Zarlingo. Respondent has proven by preponderant evidence that Zarlingo committed the actions upon which her discipline was based. With regard to the FB incident, as DON of the Rifle facility, Zarlingo was responsible for assuring that FB received appropriate care and treatment and that his rights were protected. In addition, Zarlingo was responsible for assuring nursing staff compliance with federal regulations governing long term care facilities and Rifle policies.

Zarlingo flagrantly breached her duty of care to FB. She permitted FB to be transported by unqualified staff in a car for over four hours, posing the risk that FB might have another episode of aggressive and violent behavior en route. When Zarlingo learned that Aurora South had insufficient medical information with which to care for FB, Zarlingo refused to talk to Aurora South staff, ordered Henderson not to disclose her name, and directed her nursing staff at Rifle not to talk to Aurora South staff. Zarlingo's conduct violated Rifle's transfer policy and was directly contrary to FB's physical, mental, and psychological wellbeing.

Once FB was transferred to Aurora South, Zarlingo had a duty to assure compliance with federal regulations and Rifle policy requiring written notice to FB and his MDPOA. Zarlingo violated her duty and the policies by failing to assure written notice was provided.

Respondent did not prove that Zarlingo violated medication administration policies at Rifle.

Zarlingo also engaged in conduct that was harassing and intimidating to the employees she supervised, in violation of the DHS Workplace Environment policy. That policy defines workplace harassment to include abuse of authority by making threats to an employee's livelihood. Zarlingo abused her authority by informing her subordinates, repeatedly, that they were all replaceable. She also yelled at staff in front of other staff and residents, in violation of the policy. Because Zarlingo caused so many staff to be in constant fear of her, she created a hostile work environment.

Zarlingo's threat to Barbara Kennedy, if she contacted the state Ombudsman she would be "asking for trouble personally," constitutes a flagrant violation of the Workplace Violence and Workplace Environment policies. DHS's Workplace Violence policy prohibits threats, harassment, and intimidation, which can include "oral or written statements, gestures, or expressions that communicate a direct or indirect intent to commit physical and or psychological harm." The oral threat to cause "personal harm" to Kennedy could have taken the form of career damage and physical or psychological harm. It was a serious threat to Kennedy's wellbeing. The statement confirms that staff perceptions of Rifle management as being "retaliatory" were justified. Zarlingo violated the Workplace Environment policy, the Code of Conduct, and the Workplace Violence policy.

C. The Appointing Authority's action was not arbitrary, capricious, or contrary to rule or law.

In determining whether an agency's decision is arbitrary or capricious, a court must determine whether the agency has 1) neglected or refused to use reasonable diligence and care to procure such evidence as it is by law authorized to consider in exercising the discretion vested in it; 2) failed to give candid and honest consideration of the evidence before it on which it is authorized to act in exercising its discretion; or 3) exercised its discretion in such manner after a consideration of evidence before it as

clearly to indicate that its action is based on conclusions from the evidence such that reasonable men fairly and honestly considering the evidence must reach contrary conclusions. *Lawley v. Department of Higher Education*, 36 P.3d 1239, 1252 (Colo. 2001).

Complainants assert that Respondent's actions were arbitrary and capricious because most of the investigators did not attempt to speak with Shaw or Zarlingo during the course of their investigations. They contend that the investigators' failure to obtain Complainants' side of the story evinces bias. And, they assert that this failure rendered it impossible for Manley to use reasonable diligence and care to procure and give appropriate consideration to all of the evidence she was obligated to consider. This argument is rejected for several reasons.

Manley's detailed Rule 6-10(a) letters and the attachments with dozens of detailed and specific questions assured that the Complainants knew exactly what facts were driving Respondent's consideration of disciplinary action. Moreover, the questions provided the Complainants with a meaningful and focused venue for presenting mitigating information. By using the facts culled from the investigations in her Rule 6-10(a) letters, Manley gave the Complainants a serious opportunity to refute, explain, and attack the information obtained in those investigations. This extraordinarily thorough pre-disciplinary process defeats Complainants' assertion that Respondent's actions were arbitrary and capricious under *Lawley*.

In addition, all of the investigations were conducted by professional experts in their field, relying in significant part on documents that corroborated witnesses' statements. For example, Henderson's oral report about the FB transport and Zarlingo's statements to him on the telephone were corroborated by telephone records confirming his three calls to Zarlingo at home, telephone message pad records from Rifle, Crowe's November 2007 letter to Manley, and staff charting at Aurora South. The same is true of Crowe's allegation regarding the fraudulent insurance claim: serial numbers of the AC units in unopened boxes at Rifle matched those of the units paid for with insurance proceeds; emails from Ledbetter to Shaw confirm that Shaw was informed that Crowe had fixed all of the units and that Ledbetter requested photographs of damaged units three times.

While Complainants assert that the investigators and Manley were biased against them, the preponderance of evidence does not support of this claim. Complainants suggest that Manley's initiation of four separate investigations, at great expense to taxpayers, demonstrates her intent to fire them for any reasons she could find. However, the evidence shows that all of the reports of Shaw and Zarlingo's misconduct found their way to Manley on their own; Manley did not seek out damaging information about Complainants. Specifically, Seim initiated the contact with Manley about the hostile work environment at Rifle. Months later, after receiving an on-call slip from Mike Walker for which there was no written authorization, Seim again forwarded this information to Manley. Similarly, Manley's August 2008 visit to Rifle was instigated by a state legislator after the poor 2008 state survey. Once Manley was at the facility,

she was approached anonymously by a staff member and was then contacted by Ken Henderson the following week. As Director of the Office of State and Veterans Nursing Homes, Manley would have been negligent to ignore these reports. Delegating the investigations to professional investigators in the Audit Division, at MSEC, and to her Director of Quality Management, was a reasonable decision. Manley was not motivated by any bias towards Shaw and Zarlingo.

Complainants argued at hearing that Manley lacked the required appointing authority because of the manner in which it was delegated to her. However, they presented no evidence effectively challenging the delegation.

D. The Appointing Authority's actions were within the range of reasonable alternatives available.

The credible evidence demonstrates that the appointing authority pursued her decision thoughtfully and with due regard for the circumstances of the situation as well as Complainants' individual circumstances. Board Rule 6-9, 4 CCR 801. Complainants' misconduct was flagrant and serious. State Personnel Board Rule 6-2, 4 CCR 801. Charged with the management and supervision of all resident care and business operations at the Rifle facility, Shaw and Zarlingo violated federal regulations, multiple DHS policies, and their paramount duty of caring for a resident under their protection. The decision to terminate their employment was well within the range of reasonable alternatives available to Respondent.

E. Complainants are not entitled to an award of attorney fees and costs.

Because Complainants did not prevail at hearing, they are not entitled to an award of attorney fees and costs.

CONCLUSIONS OF LAW

1. Complainants committed the acts for which they were disciplined.
2. Respondent's decisions were not arbitrary, capricious, or contrary to rule or law.
3. The discipline imposed was within the range of reasonable alternatives.
4. Complainants are not entitled to an award of attorney fees and costs.

ORDER

Respondent's actions are affirmed. Complainants' appeals are dismissed with prejudice.

Dated this 10th day of September, 2009



Mary S. McClatchey
Administrative Law Judge
633 - 17th Street, Suite 1320
Denver, CO 80202
303-866-3300

NOTICE OF APPEAL RIGHTS

EACH PARTY HAS THE FOLLOWING RIGHTS

1. To abide by the decision of the Administrative Law Judge ("ALJ").
2. To appeal the decision of the ALJ to the State Personnel Board ("Board"). To appeal the decision of the ALJ, a party must file a designation of record with the Board within twenty (20) calendar days of the date the decision of the ALJ is mailed to the parties. Section 24-4-105(15), C.R.S. Additionally, a written notice of appeal must be filed with the State Personnel Board within thirty (30) calendar days after the decision of the ALJ is mailed to the parties. Both the designation of record and the notice of appeal must be received by the Board no later than the applicable twenty (20) or thirty (30) calendar day deadline. Vendetti v. University of Southern Colorado, 793 P.2d 657 (Colo. App. 1990); Sections 24-4-105(14) and (15), C.R.S.; Board Rule 8-68, 4 CCR 801.
3. The parties are hereby advised that this constitutes the Board's motion, pursuant to Section 24-4-105(14)(a)(II), C.R.S., to review this Initial Decision regardless of whether the parties file exceptions.

RECORD ON APPEAL

The cost to prepare the record on appeal in this case is \$50.00. This amount does not include the cost of a transcript, which must be paid by the party that files the appeal. That party may pay the preparation fee either by check or, in the case of a governmental entity, documentary proof that actual payment already has been made to the Board through COFRS. A party that is financially unable to pay the preparation fee may file a motion for waiver of the fee. That motion must include information showing that the party is indigent or explaining why the party is financially unable to pay the fee.

Any party wishing to have a transcript made part of the record is responsible for having the transcript prepared. Board Rule 8-69, 4 CCR 801. To be certified as part of the record, an original transcript must be prepared by a disinterested, recognized transcriber and filed with the Board within 59 days of the date of the designation of record. For additional information contact the State Personnel Board office at (303) 866-3300.

BRIEFS ON APPEAL

The opening brief of the appellant must be filed with the Board and mailed to the appellee within twenty calendar days after the date the Certificate of Record of Hearing Proceedings is mailed to the parties by the Board. The answer brief of the appellee must be filed with the Board and mailed to the appellant within 10 calendar days after the appellee receives the appellant's opening brief. An appellant may file a reply brief within five days. Board Rule 8-72, 4 CCR 801. An original and 9 copies of each brief must be filed with the Board. A brief cannot exceed 10 pages in length unless the Board orders otherwise. Briefs must be double-spaced and on 8 1/2 inch by 11 inch paper only. Board Rule 8-73, 4 CCR 801.

ORAL ARGUMENT ON APPEAL

A request for oral argument must be filed with the Board on or before the date a party's brief is due. Board Rule 8-75, 4 CCR 801. Requests for oral argument are seldom granted.

PETITION FOR RECONSIDERATION

A petition for reconsideration of the decision of the ALJ must be filed within 5 calendar days after receipt of the decision of the ALJ. The petition for reconsideration must allege an oversight or misapprehension by the ALJ. The filing of a petition for reconsideration does not extend the thirty-calendar day deadline, described above, for filing a notice of appeal of the ALJ's decision. Board Rule 8-65, 4 CCR 801.

CERTIFICATE OF SERVICE

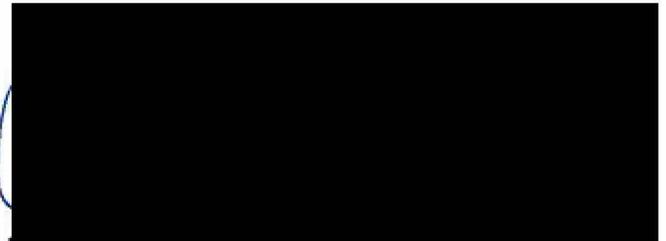
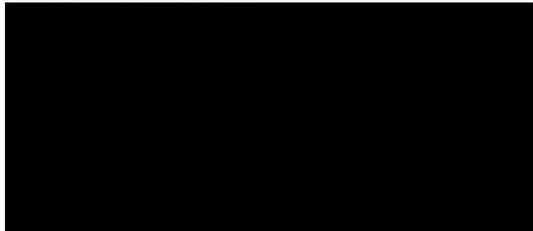
This is to certify that on the 19th day of September, 2009, I served electronically true copies of the foregoing **INITIAL DECISION OF ADMINISTRATIVE LAW JUDGE and NOTICE OF APPEAL RIGHTS** as follows:

Patricia Cookson, Esquire



and in the interagency mail, to:

Michelle Brissette-Miller
Vincent Morscher



Andrea C. Woods