**C A S E : E A S T E R # 1**

S T A T E O F M I C H I G A N
DEPARTMENT OF LABOR AND ECONOMIC GROWTH
IN THE EMPLOYMENT RELATIONS COMMISSION

*In the matter of the arbitration proceedings between:*

SOMEPLACE County Medical Care Facility, *Employer,*

Gr No. 9/28/06 - Jennifer BLUE Discharge and MERC Arbitration Case No. A06

UNION, *Labor Organization*

**APPEARANCES:**

**FOR SOMEPLACE COUNTY MEDICAL CARE FACILITY:**
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**FOR UNION**

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OPINION AND ARBITRATION AWARD

The undersigned was appointed arbitrator in a matter involving a grievance dispute between these two parties. Pursuant to the agreement of the parties, a hearing was held on Wednesday, April 11, 2007 at the Employer's place of business. Both parties submitted post-hearing briefs on May 14, 2007.

ISSUES

On September 18, 2006, Grievant was suspended for three days pending investigation. On September 20, 2007, Grievant was terminated from employment "due to resident mental/emotional abuse (#3) and resident

endangerment (#8). *See, Joint Exhibit 3.* On September 28, 2006 the Union filed a grievance alleging that Grievant had been improperly terminated. *Joint Exhibit 2.* The case raises the following issues:

I. IS THE GRIEVANCE ARBITRABLE?

II. IF SO, DID THE EMPLOYER HAVE "JUST CAUSE' TO TERMINATE THE GRIEVANT'S EMPLOYMENT, AND IF NOT, WHAT IS THE REMEDY?

The collective bargaining agreement, in the record as *Joint Exhibit 1,* has several provisions pertinent to this grievance. Section 4.3 "Resident Abuse Grievances" provides:

> In cases of disciplinary action imposed as a result of resident abuse that has been reported to and investigated by the Michigan Department of Public Health under State and Federal regulations, any grievance filed to challenge the discipline will initially be processed only through the first 2 steps of the grievance procedure. ***If the Michigan Department of Public Health, or other agency, finds the employee abused a resident, and if the decision is not reversed by appeal through the appropriate agency* or *court, termination of the employee's employment will be sustained and may not be appealed to* arbitration.** Should no resident abuse be found by the Michigan Department of Public Health, or other agency, and the Facility is not prohibited from employing the individual, the grievance that was filed above shall then be processed to the final step of the grievance procedure, arbitration if the Employer does not reinstate the individual.

Section 5.0, "Management Rights", which is a fairly comprehensive statement of the Employer's rights, states in part that the Employer has the right to maintain discipline of employees, including the right to make reasonable rules and regulations not inconsistent with the provisions of this Agreement, and to discharge, to demote, suspend or otherwise discipline employees for just cause.

## UNION'S POSITION

The Union argues that this grievance is arbitrable. Generally the law abhors the forfeiture of a valuable right such as the termination of seniority [and/or employment]. The collective bargaining agreement states only that issues of "resident abuse" cannot be arbitrated. The issue before the arbitrator is whether the Grievant was the subject of a finding of abuse or neglect. The employer did not file any written objections to arbitration, and it "struck arbitrators and mutually selected a date to hear the case". A majority of arbitrators have held that procedural objections are waived if they are not raised during the grievance process until arbitration. Thus, the Union argues that the Employer waived its claim that the grievance is not arbitrable. At the very least, the Employer's conduct should be viewed as an indication that the

Employer acknowledged that the incident did not involve "abuse", but instead involved either "neglect or misappropriation of resident property." The Union argues that the Arbitrator cannot award attorney fees because the collective bargaining agreement states in pertinent part that the fees of counsel attending the hearing shall be paid by the party incurring them. Furthermore, the Employer did not have just cause to terminate the Grievant's employment. Fundamental industrial due process was not afforded the Grievant. Grievant had no intention of harming, abusing or neglecting a resident, and this entire incident was the result of Grievant's failure to properly understand the resident's concern. Grievant thought that the resident wanted her "pop", and did not understand that the resident was asking for her stuffed animal. Grievant was merely attempting to assist a co-worker with a resident who had been upset all day and was continuing the same behavior. The resident was in fact not injured, she received her bath, and calmed down. The punishment is far too severe to fit "the crime". The Employer did not uniformly impose discipline against all of the employees who were involved. Even the findings of the State are ambiguous. The State's only finding is that an unnamed nurse failed to take safety needs into consideration. There is no finding that it was the nurse or the resident care plan that was at fault. The Union contends that we are still not sure if it was the actions of the CAN that resulted in the finding of neglect, or whether it was the Employer's failure to implement and develop an appropriate plan of action. Thus there cannot be a finding that the Grievant is "the subject of a substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency". She is not ineligible to work in a health care setting, and Grievant must be reinstated. Thus, the Union asks that Grievant be reinstated with full back pay and benefits.

## EMPLOYER'S POSITION

The Employer argues that the grievance is not arbitrable, but even if it is, there was "just cause" to terminate the employee's employment. The Employer asserts that it has preserved its right to challenge the arbitrability of this grievance. Since this matter was reported to and investigated by the Department of Public Health, and since the State "found abuse in this instance", the grievance "may not be appealed to arbitration". The Employer argues that in a similar case, decided before the new criminal background laws, Arbitrator Mark Glazer found that a grievance was not arbitrable. The Employer argues that under the statutory framework created by the Michigan Public Health Code, and the other statutes cited in the brief, the State's failure to list grievant on the Michigan Nurses Aide Registry is not determinative of arbitrability. The Employer argues that the federal regulatory authority Department of Public Health and the State Criminal Background Check Statute do not allow grievant to be employed as a CNA, and the issue of flagging on the Nurses' Aide Registry is not relevant to the disposition of this grievance. The Employer also argues that just cause existed for the Grievant's discharge. It is claimed that the misconduct which was proven in this case, more than justifies the termination of an employee in a health care setting. The Employer states that this Arbitrator can not substitute his judgment for that of the Employer because there is no evidence that the Employer acted unreasonably, capriciously or arbitrarily. Due to the prescriptions of Section

20173a(1)(i), since grievant has "been the subject of a substantiated finding of neglect [or abuser, she is no longer eligible to work in a county facility. As such the Employer asks that the Arbitrator deny the grievance that has been filed in this case, and award the Employer its costs, including attorney fees.

## THE FACTUAL RECORD

There were several witnesses who observed the events of September 15, 2006, and their descriptions of what occurred are, in my opinion, substantially consistent with respect to the seminal details. The Employer called Donna GRAPE who said that she is an "Administrative Assistant" in the Alzheimer's unit. Ms. GRAPE described herself as an office worker. She is not a direct caregiver. She "charts" files or puts "vital" resident information into the residents' records. She knows that Jennifer BLUE was formerly an employee of the medical facility in the capacity of "life enrichment aide". She saw Jennifer BLUE often, and believes that she was well liked by other employees. On September 15, 2006, she witnessed "an incident" involving Ms. BLUE. She was standing near the nurses' station "charting files". The nursing station consists of a small alcove approximately 10 feet by 12 feet in size. By agreement of the parties, the Arbitrator was allowed to view the work station, and that part of the building, where this incident occurred. The nurses' station is located near the intersection of two corridors. The alcove is "open" to the corridor. There is no wall closing off the room. An oval "dining room" type table and several chairs are in the center of the area. There is a computer work station on one wall, and a series of file cabinets on the adjoining wall. Ms. GRAPE was standing near the file cabinets. From this perspective she was able to observe about 15 or 20 feet of the adjoining corridor. She testified that she saw the Grievant, Kristina and a resident passing by in the corridor outside the nursing station. She heard the resident say something to the effect "give it back". Grievant was standing with her hands cupped together in front of her. Grievant said "follow me, come with me" and she started walking down the corridor. The resident started following her. The resident said again "give it back, you give it back". An employee named Mary Ann CARR, was the 3:00 p.m. to 11:00 p.m. shift Nursing Supervisor. She was working at the computer located in the nurses' station. Ms. CARR did not intervene in the situation in any way. She did not say anything to Grievant or tell her to stop what she was doing. Ms. GRAPE said that her shift ended at 5:00 p.m. and she went home when her shift was over without speaking to Ms. CARR or the Grievant about the incident.

Ms. GRAPE testified that the resident stopped as she passed where Ms. CARR was working, and said in a "stuttering voice", "make her .. . give it back", and was pointing towards the Grievant. The resident started "trotting" towards the Grievant, and then they all passed out of her view and continued down the corridor towards the bath house.

The resident owned a small fuzzy, plastic kitten which she carried with her most of the time as a security device. She would hold the kitten and pet it,

and she was very reliant of having the kitten in her possession. This resident was also at high risk for falling. This fact was recorded on the resident's "care plan", which the Grievant was responsible for knowing. Ms. GRAPE said that Grievant had her hands "cupped". Grievant was not holding an "energy drink". Ms. GRAPE believes that the Grievant was holding the resident's kitten, but she did not see it, and she cannot be certain. When the resident started yelling for Grievant to "give it back", Ms. CARR said "she is going to have to be given something". Ms. GRAPE testified that she thought to herself at that time that "all they had to do was to give her back her kitten" and she would calm herself down. The next day, Ms. GRAPE determined that on September 15, 2006, the date of the "incident", the resident had been given a dose of "Ativan", apparently for the purpose of calming the resident, which Ms. GRAPE did not think that she needed. Ms. GRAPE recorded certain aspects of her observation on the nurses notes. *(See, employer exhibit* 6). At a point in time, Renee ROOF came to the Alzheimer's unit„ and Ms. GRAPE informed her of the incident, and Ms. ROOF instructed her to "write it down". On September 18, 2006, Ms. GRAPE wrote out her statement, which is in the record as *Employer Exhibit 7 ].*

On cross examination Ms. GRAPE indicated that she was a "non-union" employee. She does not have any certifications. She is not a manager. She was not the shift supervisor. Although she was not a direct caregiver, she had been provided "agitated resident training". In this case, she would have "backed off' and given the resident the item so that she calmed down, and then approach the resident sometime later for the bath. Ms. GRAPE testified that she didn't discuss the situation with Ms. CARR, the Nursing Supervisor. Ms. CARR didn't discuss it with her, She didn't come over to Ms. GRAPE and ask her what she had observed. No other employee took any action to assist the resident or interfere with the way the Grievant was handling the resident. Ms. GRAPE testified that she never actually saw the kitten, and she didn't see it being taken, and despite what is written in her note, she didn't remember seeing the Grievant take the kitten. She said that she believed that Grievant had the kitten but she didn't actually see it in Grievant's possession. Her memory and her note don't reconcile in this regard. Ms. GRAPE has not had training in "how to handle Alzheimer's residents". She never worked as a C.N.A., although she testified that she was an EMT for 20 years. She was not required to use any of her EMT experience in connection with this incident.

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The written statement provided: "On Friday, September 15, 2006, at approximately 3:30 PM I was charting vitals. Suddenly Jen V started walking very quickly towards the bath house with a patient following yelling at Jen to "give it back". MaryAnn 0. was sitting at the computer and the patient stopped, and was agitated and was telling Mary Ann and pointing that she had to make her (Jen) give it back. Then the patient started to quickly walk towards Jen, continuing to yell. MaryAnn stated that she was going to need Ativan. I either thought or said she needs her kitten back. Jen came back to the nurses station smiling stating that the patient was getting a whirlpool and Kristina was taking care of the kitten. From what Jen said when she came back to the nurses station I believe what had happened was the patient went to the bathroom by the nurses station and Kristina was holding the kitten, that the patient always carries with her, while she was in the bathroom. When the patient came out, Jen took the kitten from Kristina in order to get the resident in the Bath House.

Ms. MaryAnn CARR was called by the Employer. She testified that she was the "3 to 11 charge nurse" in the Alzheimer's unit. She is the supervisor on the unit from 2:30 p.m. to 10:30 p.m. She knows the Grievant as having been employed in the unit. On September 15 she was at the computer in the nurses' station. At a point, she became aware of "a commotion". A resident was very upset. The resident passed by her "on the right side" and began to move down the hallway. She believes that Kristina was involved. She was trying to get the resident down to the bath house for her whirlpool bath. Ms. CARR said that she "turned around" to see what the commotion was all about. The resident was saying "give it back". Kristina was ahead of the resident. Ms. CARR saw the Grievant down the corridor and assumed that she had gone down to get the whirlpool ready. The patient was all upset. The patient said "I want that" back. When Ms. CARR looked down the hallway, she could see "an energy drink" in Grievant's hand. Kristin had clothes folded over her arm. The resident "was moving right along". The resident is easily upset and was previously involved with some other residents. She can be pushy and aggressive. The resident had a lot of stuffed animals, and she always had a little stuffed kitten with her, which she really loved to have. Ms. CARR said the patient "really thought a lot of that little kitten". She also had "mobility issues" in that she would easily fall, and so it was not good that she was moving fast. Ms. CARR didn't recall if the resident was in the "fall program" or not, but it is upsetting when a resident is "emotional like that". She was concerned about the resident's safety and the safety of other residents. This resident had been pushing another resident, and had fallen. She was aggressive, and would go after other patients. She had been separated from the other resident. Later that evening, Ms. CARR gave the resident a dose of ativan to quiet her down. This was not sleep inducing, but it did quiet her down. She does carefully give medication to the residents sometimes. Sometimes you can quiet them down by just re-directing and in this case, the whirlpool also helped. She had already pulled the ativan and just decided to give it to her. The resident had been anxious during the daytime, and as evening progresses the tendency is to get more agitated, and that's why she chose to give the ativan at that time. She was asked by Kurt NOOK, the Director of Nursing, to write up a statement which she did, and which is in the record as *Employer Exhibit 8* [2].

The Union called Kristina LIGHTS to testify. Ms. LIGHTS had recently resigned her position at the medical facility. She knew the grievant through work. They worked together from November, 2002 through Grievant's termination. She wrote out a statement at the request of the employer, in the

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[2] The written statement indicated "I was at the computer when I became aware that a resident was upset and was yelling about wanting something that she thought belonged to her. Kristina was with her and was attempting to guide her down the hall towards the whirlpool room. The LEA's were wanting to give her, her scheduled whirlpool which she had refused on the previous shift. Jen was down the hall near the dayroom/whirlpool area. I noted that she had a large can of soda. in her hand. I concluded that was what the resident wanted as she was quickly heading down the hall. Kristina was at her side. Following her whirlpool I gave PRN ativan as I was concerned for her safety as well as others. In the past she had hit out at other residents as well as being pushed to the floor. I medicated her around 4 PM."

record as *Union Exhibit 9* [3], and then later wrote out another one, which is in the record as *Union Exhibit 10.* [4] The second statement was written a day or two after the first one. She testified that the statement was written on September 20, 2006, one day after Grievant's termination, but that at the time she thought the Grievant was still "on suspension". By the time she wrote the second letter she knew that Grievant "was in trouble". She felt hurried when she wrote the first statement because there was a ward clerk sitting there waiting for her while she wrote it out. She was trying to hurry up with the facts. She wrote it out fast and in a hurry and didn't really think about it. When Grievant got into trouble, she was trying to find out what the problem was with the cat. She understood the difference between "abuse", forcing the patient to do something, and "neglect", not taking care of the patient's needs. She said that on the day in question, she came on shift. She came on the shift at about 10 minutes to 3, and first thing she did was check her records. She picked up her papers and resident's sheets and reports. They went to snack time and they talked like always. This particular resident was in a bad

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3 Kristina's first statement says "I went and got residents, room #123, clothes and her stuffed cat and I came out to the desk where the resident was. Jennifer was also out at the desk and I asked her to help me to see if she could get the resident to go and take a bath. (because her hair was very dirty for a few days and she needed it washed.) (the resident. was also very agitated w/me so I didn't want to take her because I didn't want to upset her more) and we started to walk down the hall a little bit. We got to about Dining Room A and she saw the cat as I was trying to hand it to Jennifer and she started to get upset and yell that she wanted it and Jen told her we would give it to her and to come w/as. And then she followed us to the Bathhouse.

4 Kristina's second statement stated: "I Kristina LIGHTS was working with Jennifer BLUE on September 15, 2006. I came to the soda shop and sat down next to the Resident from room #125 and I tried to talk with her. I asked her how her snack was and she wouldn't talk with me and then she stated that she had to use the bathroom so I told her I would take her, then we both stood up and I asked. her to set her snack down because *we* couldn't take it to the bathroom and she get upset and slapped me in the chest area and walked down the hall to the nurses station. I went to the nurses station to see if she would let me help her to the bathroom, and she said no and then I asked the nurse on duty to try and take her because she was upset with me (and I just wanted to make sure that she had gotten to use the restroom). (The Resident's hair was very dirty and she in need of a bath). I asked Jennifer to help get her a bath because she was upset at me and she didn't want my help. Jennifer agreed to help and I went and got her clothes and I also got her toy cat (because it usually helps put her into a better mood, I figured that we could give it to her when she got to the bathhouse so she would be in a better mood to talk into a bath. I came out of the room w/her stuff and Jennifer was talking to the resident and we asked her to come w/us and as Jennifer and I. were walking I showed her that I had the cat and gave it to her and she put it into her pocket and kept walking down the hall and then the resident started to yell "give me that", "I want that" and started to walk fast, not quite run after Jennifer, yelling at her "I want that" and "give me that". Jennifer was about 10 or 15 feet ahead of her and she had her monster Energy drink in her hand and I was next to the resident trying to 9et her to slow down and then the resident yelled "give me my baby" and Jennifer stopped by Family Room "A", and said OK come on, I'll give it to you and took the cat from her pocket (Because the resident calls her cat her baby, she must have realized what she was yelling about.) and gave it to her when she got to Jennifer and the resident came into the bath house w/us and she got into the bath tub and got washed up and after she was all done she told me she felt better and hugged me and said "thank you". And she came out whistling and in a good mood and sat by the bird with me. But when the nurse try to give her her meds, she got snippy and said "no" and then I asked her to help me w/setting the tables and she said yes. *We* went into dining room B and. another resident . . . (illegible). . us around and kept asking questions and the resident from room # 125 was getting mad and telling her to leave and then she start to yell at her so I asked some one to come help me 9et the other resident and see if they could do a 1:1 w/her, and even after they left the room the resident from Room #125 was still agitated so I told the nurse and she gave her meds and the resident had a good night the rest of the night".

mood. She had been agitated in the previous shift. She was not talking and she was agitated. Ms. LIGHTS gave the resident her snack, but the resident would not eat it. Ms. LIGHTS tried to talk to the resident. The resident got upset and said she had to go "to the potty". She had a cup of pudding which Ms. LIGHTS asked her to put down. The resident started squeezing the cup and pudding "was going everywhere". When Ms. LIGHTS was cleaning up the pudding, the resident "took off" and headed for the nurses station. Ms. LIGHTS told the nurse that she didn't know what to do, that the resident had "smacked" her, and she asked the nurse if she would take the resident to the toilet. She thought that another person might calm the resident down. The grievant came up, and she and Ms. LIGHTS talked about whether they could get her into the bath tub. Ms. LIGHTS went to get the resident's clothes. She decided to bring the resident's cat, because she thought that would be a positive thing, and she had been taught to try and comfort the residents to make them happy. She gave the resident's clothes to the grievant at the nurses station, and they all started down the hallway. A little ways down the resident started becoming upset and said "I want that". Grievant had a "monster" energy drink. The grievant was in front, and the resident was next, and Ms. LIGHTS was right behind the resident. The resident was going pretty fast, and Ms. LIGHTS was trying to get her to slow down. Grievant said "come with us and I will give it to you". The patient was walking really fast. She was a "mobility risk". The resident was yelling at the Grievant. She didn't fall, *but she was more upset than usual.* The nurse supervisor was right there. She might have been charting, but she didn't say anything. Then they got to the whirlpool and the resident remained upset for a bit, but then she calmed down a lot after the bath. The Grievant left as soon as the resident got into the tub. Ms. LIGHTS said that the cat was a little plastic figurine about 2 inches or so long. She had given the cat to the Grievant along with the resident's clothes. Grievant put the cat in her pocket. She had the resident's clothes in one hand, the drink can in the other, and the cat in her pocket. Grievant did not have her hands "cupped". She saw the Grievant give the cat to the patient by the bath house.

After the bath, Ms. LIGHTS and the resident sat down together "by the bird". Another resident came along and started to agitate the resident, and Ms. LIGHTS took her into the dining room to set the table. Ms. LIGHTS said that she had worked with this resident for several years. Generally the patient will go along but on that day she was agitated. There have been past instances where she was agitated, but they can usually get her to calm down.

Ms. LIGHTS testified that she was not disciplined for her involvement in the incident. She was provided an in-service, but was not disciplined.

The Employer called Director of Nursing Renee ROOF to testify. She said that she supervises the nursing department. She also knows the Grievant through work. She had a role in Grievant's termination. She did the investigation and participated in the discussions with Greg TREE and Kurt NOOK. Grievant was a Life Enrichment Aide in the Alzheimer's unit. The Alzheimer's unit is structured to provide resident's with a calm environment. The patient/staff

ratio is much smaller than in the general unit. In other words, there are a lot more staff per resident working at any given time. The Assistant Director of Nursing told her to talk to Donna GRAPE and Donna GRAPE, who was upset, told her that a patient had been medicated for agitation. She said that Donna told her that the resident was at the desk with the Grievant, and the Grievant had her hands cupped around something. The Grievant was walking fast, and the resident was yelling "that's mine". Donna told Ms. ROOF that she overheard Mary Ann say something to the effect that "she will need ativan". Donna GRAPE was upset because she felt that the medical staff caused the agitation and the administration of medications was wrong. She felt that the patient had got upset when Kristina passed the cat to the Grievant. Kristina gave Ms. ROOF a written statement also. After she spoke with Kristina, Ms. Allley also spoke with Grievant and had her come into work. The Grievant wrote out a statement, in the record as *Employer Exhibit 11.*[5] Ms. ROOF said that she did not tell Kristina what to put in the statement, or put any time constraints on writing it. Kristina had a half hour or so to write. Ms. ROOF sent a ward clerk to get the statement. The statement was consistent with what shat told her earlier. She took a written statement from Grievant. She asked Grievant what happened. Ms. ROOF said that no one objected to giving her a written statement. She always asks for a written statement from employees concerning employee/resident issues. She is required by the State to do a thorough investigation and it all needs to be in writing. In this case the State wanted more detail. After discussing the matter, it was decided to suspend the Grievant, and the next day it was decided to terminate her employment. The suspension was based on what Donna GRAPE and Kristina told her, that Grievant's conduct constituted "anguish/mental abuse" under the statutes. This was because the resident was agitated, and she wanted what was in Grievant's hand. The grievant kept backing up and this caused the resident to become more agitated, and also to walk more quickly. The Employer decided that this was "abuse" which had to be reported because it caused "mental anguish", and also resulted in unnecessary medication. The Employer believed that the grievant's conduct violated state regulations because it constituted mental anguish, and it also violated Rule No. 3 of the employer's handbook *(See, Joint Exhibit 5,* page 10 "Violations of the following work rules will result in discipline, up to and including discharge on the first offense . . . 'mental abuse: includes threatening a resident with physical or psychological harm as well as taunting or teasing a resident". ) On September 2, 2006, Kurt NOOK reported the incident to the State as an incident of "abuse". *(See, Employer Exhibit 12).* [6] This report is notice to the State,

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[5] I came into work. Resident was agitated when came on shift. Kristina saw resident's hair was dirty so she wanted to put resident in bath. Was asking for my drink. I told her no, Kristina went to get [resident's] clothes, came back, pulled kitten out from under clothes. I put it in my pants pocket and started to walk away. Resident started to follow me saying I want that give it to me. I thought she was talking about my drink, until we got closer to bath house, said give me my baby. I walked into the bath house where I set the cat on sink 3. Resident said "OK". I then left the bathhouse, resident was not agitated when she came out of bath.

' The "Facility Investigation Report" identifies Grievant by name, contains a number that is indicated as being the Grievant's 'registry number" and indicates that "resident wanted an item that staff member was carrying in the hallway. Resident grew agitated and began chasing staff member down the hallway and staff member continued walking rapidly. Resident agitation and endangering resident who is a fall risk. Staff

and they will then come out and investigate the incident. In this case the State did investigate, and they came out and took all the documentation. The Employer received a citation for the incident and had to pay a fine. *(See, Employer Exhibit 15).* The State also issued a "statement of deficiencies and plan of correction" in the record as *Employer Exhibit 13,* which provided in pertinent part:

> Resident 2 was an 81 year old female residing on the dementia unit . . . reports for 9/15/06 indicated that a staff member (CNA) had taken a resident's stuffed kitten in order to entice the resident into taking a bath. Per the reports, the resident "became agitated and began chasing staff member down the hallway and staff member continuing walking rapidly. The actions by the staff member were confirmed in a statement from another staff who wrote "(CNA Name) took kitten and walked quickly away w/(with) (resident's name) following and yelling "give that back". (CNA Name) kept walking - wanted to get (Resident's name) a bath". According to Resident 2's care plan for falls dated 8/11/05, the resident was "at risk for falls R/F history or and recent falls ...impaired cognitive skills...unsteady standing balance." *The CNA failed to take Resident 2's safety needs into consideration, making the resident agitated and attempting to run after the CNA to retrieve her property resulting in an increased risk for falls and possible serious injury.*

Grievant testified that she began working for the Employer in 2001. She was hired as a CNA on the second shift. She had to go through 120 hours of training. She had a license when she hired in and she still has it. At some point in time in 2005 she transferred to the Alzheimer's Unit. She went through extensive in servicing and training. The unit is selective in who it employs. She had to provide references from nurses, supervisors and relatives. With respect to the September 15 incident, Grievant had known the resident involved for quite some time, since Grievant was about 5 years old. Grievant knew the resident personally and professionally. On September 15, 2006 Grievant started working at 2:50 p.m. and was scheduled to go home at 11:00 p.m. At the start of the shift, Grievant went into the "mods room" and got her report. She got her vitals ready and picked up a radio, At the beginning of the shift residents are usually taken to the social room for snacks and for conversations and the like. Each day, each CNA has a sheet listing their hall assignment. Grievant did not remember if the resident in question was on her sheet on September 15, 2006 or not. At a point she went down to the nursing desk to "put her vitals on the board". She was carrying an "energy drink" which she sat on a table. The resident reached for the drink, and Grievant told her that "you can't have it". Grievant had purchased the drink at a gasoline station on the way to work. The drink was open and "she should have put it in a Styrofoam cup." Kristina approached the Grievant and asked if Grievant would help her take this resident to the bath. Kristina left for a brief period and returned with the resident's clothes and the kitten. Kristina handed the clothes and the kitten to Grievant. So that she would not

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actions appear to be mental abuse of a resident and placed. resident into an endangered situation.

lose the kitten, Grievant put it into her pants pocket. She gathered up the resident's clothing, and started walking down the corridor towards the bath house. The resident was yelling. Grievant didn't do anything about the yelling as they moved down the corridor. When the resident reached approximately the "sitting room", she yelled "I want it. It's mine. Give me back my baby." Grievant said that at that point she realized the resident was calling for the kitten, and so she held it out, and when the resident came up, Grievant offered the kitten back to the resident. Grievant said that she, the resident and Kristina had been walking down the hall. The resident was behind her, and the Grievant thought that the resident was yelling for her "energy drink". She did not stop at any point until she heard the resident ask for 'her baby' and realized what was going on. In any event, Grievant indicated she held the kitten out, but the resident didn't want it. She kept walking and entered the bath house. The resident would not take the kitten, so Grievant sat it down in the bath house. Kristina gave the resident the bath, and Grievant left the area. She said that she interacted with the resident many times during that shift without any further problems. She did not file an incident report, and no one spoke to her about what had happened. On September 18, 2006 she found out that there was a problem. She came in, punched in, went to the desk, and was told that she needed to go to Renee's office, and that Renee was going to do "an investigation". Grievant was told that "you need Union counsel. Get Barb Sherman". Grievant reported to Renee's office and was there for about an hour. She gave a statement to Renee after Barb Sherman arrived. Grievant was asked to write out what had happened on the 15th. Grievant indicates that she only had three to five minutes to write out a statement. On September 20, 2006 Grievant was informed that her employment was going to be terminated, and she asked that the termination notice be faxed to her. A grievance and this arbitration followed.

## DISCUSSION

The first question to be decided is whether the grievance is arbitrable. As indicated, the collective bargaining agreement provides that if *the Michigan Department of Public Health,* or *other agency, finds the employee abused a resident, and if the decision is not reversed by appeal through the appropriate agency or court, termination of the employee's employment will be sustained and* may *not be appealed to arbitration.* The State investigators did not actually use the word "abuse" in the deficiency letter it issued in connection with this case. The Employer reported Grievant's conduct to the State as "abusive conduct". The Employer's "plan of correction" states that as a result of the incident, "all staff will be in serviced for *abuse* prevention". *(Employer Exhibit 13,* page 5). The employer's evidence demonstrates that the Employer not only considered Grievant's conduct as "abuse", but it reported Grievant's conduct as such, and was subjected to administrative sanction as a result. However, as the Union correctly points out, the DHHS *(Employer Exhibit 13)* does not unequivocally state that Grievant's conduct constituted "abuse". The "non-arbitrability" clause is triggered only when a *state agency* "finds the employee **abused** a resident". The question becomes whether the agency must actually use the word "abuse" in its findings. Or is it sufficient under the collective bargaining agreement if the State agency describes conduct that constitutes

"abuse". The finding the state made was that the Grievant "**failed**" to take the resident's safety needs into consideration. Is this "abuse" or is this "neglect". I cannot say for certain. The "F-tag" assigned by the State is F224, which as I understand it is the code for violations of 42 U.S.C. 483.13c, which requires procedures prohibiting mistreatment, *neglect and abuse* of residents. While the contract does not explicitly indicate that the State's findings have to use the word "abuse", in my opinion, it does require that the State's findings be explicit enough for the parties to know with some degree of certainty when a finding of "abuse' has been made. I am unable to conclude that the State investigators unequivocally characterized Grievant's actions as "abuse of a resident". Consequently, I do not think that the finding made by the State bars arbitration in this case. In my opinion, the grievance is arbitrable under the arbitration provisions of the collective bargaining agreement.

The second question then becomes whether the Employer had just cause to terminate the employment of the grievant, and if there was no just cause, what is the remedy? The Employer argues that in terms of a possible remedy, the Grievant is ineligible for reinstatement since she is no longer eligible to work in a county medical care facility under MCLA 333.20173a. MCLA 333.20173a provides in substance that a county medical care facility shall not employ any individual who has been the subject of a substantiated finding of neglect, or abuse by a state or federal agency *pursuant to an investigation conducted in accordance with 42 USC 1395i-3 or 1396r.*

42 USC 1395i-3 provides in substance that the State shall provide for a process for the investigation of allegations of neglect and abuse of a resident in a nursing facility. *The State shall, after providing the individual involved with a written notice of the allegations (including a statement of the availability of a hearing for the individual to rebut the allegations) and the opportunity for a hearing on the record, make* a *written finding as to the accuracy of the allegations. . . ."* There is no indication in this record that the State gave Grievant notice of the allegations and the opportunity for a hearing on the record, and thus *it does not appear* that section 20173a directly applies to this case.

Thus, the real issue becomes whether the Employer had "just cause" to terminate the Grievant. The standards of just cause have been well established. Most people involved in labor and management disputes rely on Arbitrator Daugherty's decision in ENTERPRISE WIRE CO. (46 LA 359, 1966) to establish the seven standards of just cause. Those standards include: "Did the Company, before administering discipline to an employee, make an effort to discover whether the employee did in fact violate or disobey a rule of management?" Daugherty states that an employee has the right to know with reasonable precision the offense with which he is being charged and to defend his behavior. Daugherty also opined that the investigation must normally be made before the employer makes its decision. If the employer fails to do so, it may not be excused on the grounds that the employee will get his day in court through the grievance procedure after the exaction of the discipline.

Joint Exhibit 5, the Professional Handbook, page 10, provides that violations of designated work rules, including abuse and neglect of residents, will result in discipline, up to and *including discharge on the first offense,* and reporting of violations to the appropriate licensing agencies. Mr. NOOK said that the Employer uniformly terminates the employment of all employees who are found to have engaged in substantiated acts of abuse or neglect, and the employee is reported to the state. In this case, he said that the mental agitation that was described by witnesses was determined to be abuse, and it was his understanding that the State had also substantiated "abuse". He said that Grievant should have stopped and resolved the agitation. Greg TREE, the CEO, testified that "no one ever kept their job after having found that they engaged in abuse or neglect of a patient". He said that that plan of correction was prepared and sent in to the State, and that at a point in time it was accepted by them, but the Employer had to pay the $350.00 daily fine from October 26, 2006 until February 15, 2007 (possibly subject to a 35% reduction for waiving appeal rights apparently).

In this case, I accept Grievant's testimony that she did not intend to harm the resident. Even so, it is clear that her interaction with the resident on September 15, 2006, caused the resident to experience heightened anxiety, and increased the risk that the resident could have fallen and injured herself. Despite the fact that the State did not explicitly use the word "abuse", it did make a finding of fact that the Grievant ". . . *failed to take Resident 2's safety needs into consideration, making the resident agitated and attempting* to run . . *to retrieve her property resulting in* an *increased risk for falls and possible serious injury."* In a healthcare setting, where the safety of vulnerable adults is at risk, this is, at least in the employer's eyes a serious infraction. The work rule specifically says that abuse and neglect of residents, will result in discipline, up to and *including discharge on the first offense.* Although Grievant may not have intended to harm or injure the resident, she was put on notice that the Employer viewed "abuse or neglect" of patients as a very serious offense, warranting termination of employment. At a minimum, Grievant's conduct constituted "neglect" of this resident, and despite the state's failure to describe the conduct as "abuse", probably also constituted "abuse", at least within the meaning of the employer's policies. In light of this, the Grievant's conduct constituted just cause for her termination.

The Employer has requested that it be awarded attorney fees. Section 4.2(e) provides that the *fees* and wages of representatives, *counsel,* witnesses or other persons attending the hearing shall *be paid by the* party *incurring them.* The arbitrator has no authority to "add to, subtract from, modify, change, alter or amend the terms and conditions of the Agreement". In light of this restrictive language, this Arbitrator does not have authority to award attorney fees to the Employer.

**AWARD**

The grievance is arbitrable since I cannot unequivocally determine whether this F224 violation was based on "abuse" or "neglect".

The Employer had just cause' to terminate the Grievant's employment.

Pursuant to the language in the collective bargaining agreement, each party is responsible for its own costs, and no attorney fees are awarded to either party.

Each party is to bear one-half of the costs of the arbitrator.

Alvis Philip Easter (P27168)

June 13, 2007.

*STATEMENT FOR SERVICES*

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|---|---|---|
| *4-11-07* | *Full day hearing @ OCMCF* | *$500.00* |
| *6-11-07* | *Study, research and draft award* | *$500,00* |
| *6-12-07* | *Study, research and draft award* | *$500.00* |
| | | |
| *4-11-07* | *Travel - 485 miles @ 48.5/mile* | *$235.22* |
| | | |
| | *TOTAL:* | *$1735.22* |

One-half payable by Employer: $867.61

One-half payable by Union: $867.61