

IN RE ARBITRATION BETWEEN:

TEAMSTERS LOCAL 160

and

ADAMS HEALTH CARE CENTER

DECISION AND AWARD OF ARBITRATOR

BMS CASE # 10-PA-0516

JEFFREY W. JACOBS

ARBITRATOR

February 25, 2010

IN RE ARBITRATION BETWEEN:

Teamsters Local 160

and

Adams Health Care Center

DECISION AND AWARD OF ARBITRATOR
BMS Case # 10-PA-0516
Maureen Bergan grievance

APPEARANCES:

FOR THE UNION:

Frederick Perillo, Attorney for the Union
Maureen Bergan, Grievant
Wayne Perleberg, Sec'y Treasurer Local 160
Tammy Loecher, LPN/Union Steward
Patricia Swenson, CNA
Dawn Mullenbach, CNA/TMA
Cheryl Learmont, former CNA

FOR THE EMPLOYER:

Steven Hovey, Attorney for the Employer
Julie Schmitz, Administrator
Diane Ahrens, former Director of Social Services
Jane Krumenauer, RN with Pathway Consultants
Erin Mullenbach, CNA
Tammy Drake, RN with Pathway Consultants

PRELIMINARY STATEMENT

The hearing in the matter was held on February 1, 2010 in the law offices of Hoversten, Johnson, Beckmann & Hovey, in Austin Minnesota. The parties submitted Briefs that were received by the arbitrator on February 16, 2010 at which point the record was closed.

CONTRACTUAL JURISDICTION

The parties are signatories to a collective bargaining agreement covering the period from October 1, 2009 to September 30, 2011. Article 8 provides for submission of disputes to binding arbitration. The arbitrator was selected from a list provided by the Minnesota Bureau of Mediation Services. The parties stipulated that there were no procedural arbitrability issues and that the matter was properly before the arbitrator.

ISSUES PRESENTED

The parties stipulated to the issues as follows: Did the Employer have just cause to terminate the grievant? If not what shall the remedy be?

EMPLOYER'S POSITION:

The Employer's position was that there was just cause to terminate the grievant for her actions in this matter. In support of this position the Employer made the following contentions:

1. The basis for the Employer's actions was that it terminated the grievant for her willful behavior in leaving a resident known as resident 113W, in a lift in the bathroom alone. The Employer alleged that this was a dangerous action that could have led to the resident's injury or even death.

2. The Employer noted that the collective bargaining agreement does not define the legal standard for just cause and argued that the standard should therefore be given its common meaning as defined in Minnesota caselaw. The Employer cited the well-known case of *State Ex Rel. Hart v Common Council of Duluth*, 55 NW 2d, 118 (Minn. 1896) for the definition.

3. The Employer further argued that the grievant acknowledged that she left the resident alone on a toilet while attached to the lift so there is no dispute about the salient facts of this case. The Employer pointed to three separate violations and asserted that any of these individually could have provided ample justification for the grievant's termination. These will be discussed below. The grievant further acknowledged that she knew of the resident's care plan and that she had been given the so-called pocket sheet she could carry with her to provide instructions for each resident without having to run back to the nurses station to get that information. The Employer noted that the grievant hooked up this resident and left her to go back to the nurse's station. While she may have been gone for a few minutes and fortunately nothing happened to the resident the Employer noted that this is not the point – something clearly could have and it takes only a second or two for something horrible to happen if they are left alone.

4. The Employer also pointed to the context in which this matter arose. The Health Care Center had been the subject of an ongoing series of audits by the State of Minnesota and had been told that it could lose its certification unless serious and sweeping changes were made.

5. In response to this the Employer contracted with a company called Pathway Consultants to make sure it complied with all applicable State and Federal regulations regarding the administration and operation of nursing homes. Failure to comply would have meant that it would no longer be able to take Medicare eligible patients. That in turn would have meant the closure of the Health Care Center as many of its patients are on Medicare. It was in fact one of the consultants from pathways that found the resident in the lift alone with no one around to watch her.

6. Pointing now to the grounds for the termination the Employer first asserted that the grievant ignored the specific resident's specific care plan that clearly called for her to watch this particular resident even when she was in the bathroom. The Employer pointed to this resident's care plan dated October 5, 2009, Employer Exhibit 3, that provided in relevant part as follows:

Resident does request not to be unhooked from stand-up lift while toileting. She should NOT be left hooked up. Give her the option either to have a walker placed in front of her or a stool for her feet, but don't leave her hooked up to the stand-up lift. She requests aides to stand outside of bathroom while toileting. Respect her dignity, but DON'T leave her alone with the e-z stand hooked up. (Emphasis in original)

7. In addition, the pocket sheet that the grievant had with her also provided a clear instruction as to what to do with this resident and told her not to leave the resident alone. This provides as follows: "Do not leave her alone hooked up to the lift. Give her a walker placed in front of her or a stool for her feet." The Employer also noted that this care plan had been in place since August 2009 and that the grievant clearly knew what she was supposed to do when toileting this resident yet she completely failed to follow these care plans.

8. The grievant acknowledged that she would have seen this and that even though it is dated October 5, 2009, it would have been the same sheet she had with her when she was dealing with that resident. Further, the grievant is a long term employee and was well aware of her responsibility to review these care plans and follow them in order to provide a safe environment for the resident.

9. Next the Employer pointed out that the Health Care Center has a well-communicated well-understood policy against leaving residents alone in lifts such as this. The grievant was well aware of her obligation to watch the residents at all times and make sure that they do not slip or become entangled in the lift straps yet she ignored these clear requirements. Failure to follow a care plan was specifically mentioned at a meeting held only weeks before this incident as grounds for termination. The Employer played a short video showing a management employee clearly admonishing the staff to follow those care plans and that she “hated” to have to fire an otherwise good employee for failure to follow these plans. The Employer argued, the message was clear – follow the care plans or else.

10. The Employer also cited State regulations regarding following care plans and resident safety, see Minn. Rule 4658.0300 and Federal Regulations see 42 C.F.R. 483.13, as further grounds for the grievant’s termination. These regulations clearly provide that residents must be free of any physical restraints for discipline or convenience. Here the grievant left because she wanted to go to the nursing station to get something and the Employer argued that this was at best for the grievant's convenience. Even though “she felt the resident was safe” this placed the resident in serious potential for harm and cannot be excused because “nothing happened.” The Employer argued that the standard cannot be one of “no harm no foul.”

11. The Employer argued that there is thus no question that some discipline must be meted out and that the sole question is whether the punishment fits the crime here. It argued that termination was the only appropriate remedy given the seriousness of the offense and the grievant’s record.

12. The Employer acknowledged that the grievant has been employed for a long time but asserted that she has been specifically warned not to leave residents alone in the past yet she ignored these clear directives. The Employer pointed to an incident in 2006 in which the Director of Nursing Tanee Reeves specifically admonished the grievant not to leave residents alone. Given the grievant’s failure to follow clear directives the Employer argued that she cannot be trusted to follow them now.

13. The Employer further dismissed the Union's claim that “everyone else does it too” and argued that this does not excuse a clear violation of State and Federal regulations nor does it justify ignoring the clear directives on a resident care plan. If management had been aware that aides were in fact leaving residents in these types of lifts they would have put an immediate stop to it.

14. Finally, the Employer assailed the credibility of Union witnesses and exhorted the arbitrator to reject the grievant's testimony as self serving and a thinly veiled attempt to avoid being fired for what she should have known was a terminable offense. Further, the Employer pointed to its witnesses many of whom had no interest in the outcome of the case but who were giving a straight and accurate version of their understanding of the policy in place and of the facts of this incident. Their version, the Employer argued, was beyond reproach and should be accepted here over the Union's.

15. The essence of the Employer's case is that the grievant willfully violated a clear directive and a clear provision in this particular resident's care plan NOT to leave her alone in a lift and that she had been warned and even disciplined for this in the past leaving the Employer with no choice than to terminate her to make sure this does not happen again.

The Employer seeks an award of the arbitrator denying the grievance in its entirety.

UNION'S POSITION

The Union's position was that there was no just cause for the termination here. In support of this position the Union made the following contentions:

1. The Union acknowledged that the grievant was working with the resident on the day in question and that she placed her in the E-Z lift in order to have her use the toilet. The grievant further acknowledged that she left for a few minutes to retrieve something from the nurse's station and was gone for only a minute or two and was on her way back when Ms. Ahrens confronted her. There was thus no dispute about the underlying facts of what happened.

2. The resident was not in any danger; the lift was properly hooked up and the resident could not have gotten out of it or slipped off the toilet. The lift has certain safety devices, such as foot treadles and a vest to keep the resident solidly in place. There is literally no way that a resident once properly placed in the lift can fall or slip out of it. Thus the assertion that “something bad could have happened” is simply overblown and not true.

3. The Union pointed to the commonly accepted “tests” for determining whether just cause exists to impose discipline that were first articulated by Arbitrator Carroll Daugherty in *Grief Bros. Cooperage*, 42 LA 555, 558 (1964). See also, *Enterprise Wire Co.*, 46 LA 359 (Daugherty 1966). The Union asserted that a negative answer to any of these questions may well mean that there is insufficient cause for the discipline imposed. These tests are as follows:

- A. Did the Company give to the employee forewarning or foreknowledge of the possible consequences of the employee’s conduct?
- B. Was the Company’s rule or managerial order reasonably related to the orderly, efficient and safe operation of the Company’s business?
- C. Did the Company, before administering the discipline to the employee make an effort to discover whether the employee did in fact violate or disobey a rule or order of management?
- D. Was the Company’s investigation fair and objective?
- E. At the investigation, did the “judge” obtain substantial evidence of proof that the employee was guilty as charged?
- F. Has the Company applied its rules, orders and penalties evenhandedly and without discrimination to all employees?
- G. Was the degree of discipline administered by the Company in a particular case reasonably related to (a) the seriousness of the employee’s proven offense and (b) the record of the employee in his service with the Company?

4. The Union asserted that literally none of these tests were met in this case and that the Employer’s lack of notice to the employees, lax enforcement of any rule even if it was in place, their poor record keeping and the lack of any showing that the resident was in any danger overwhelmingly supports an award sustaining the grievance.

5. The Union asserted that there was no policy in place against leaving the residents in these types of lifts and that at no point was such a policy ever communicated to the grievant or the staff in general. The Union alluded to the fact that the motivating factor in all of this might well have been the ongoing audit process that was happening at around the time this incident occurred.

6. The Union asserted that it was common practice to place residents in these types of lifts and that all staff, including aides and nursing supervisors have done it routinely. The Union asserted that if there was such a rule, it was certainly never enforced and that in fact management knew of this practice and did nothing to stop it or to place the staff on notice of any such change.

7. The Union noted that the Employer promulgated a new policy against leaving residents in lifts only *after* the incident in question. This shows that the Employer knew it did not have a policy at the time of this incident and had to create one retroactively to justify terminating the grievant.

8. The Union introduced testimony from both other aides as well as nursing supervisors to show that they too had no idea there was such a policy in place and that they would have done the very same thing the grievant did that day for the same reasons.

9. The Union further assailed the Employer's assertion that the grievant had been warned in 2006. The Union pointed to the "discipline" notice and noted that it was not signed by the grievant or a supervisor and never shared with the Union. Moreover, on the back of the so-called disciplinary notice there was a reference to two aides who were allegedly involved yet the other aide, who did testify, was not given any discipline. It is therefore clear that there never was any discipline in that 2006 incident.

10. The Union also pointed to the testimony of Employer witnesses who acknowledged that when they sent in the form about the October 2009 incident here; they indicated that the grievant did not in fact have prior discipline on her record. This presumably came upon a review of her record and that the Employer is simply wrong when it said that the grievant has prior discipline.

11. The Union also assailed the investigation and pointed out that in the documents sent to MDH about this, it indicated that the grievant had already been fired when in fact management had not even met with her to discuss the incident. The Union asserted that it was thus clear that the employer was again trying to bolster its already flagging image with the State by showing that they had taken decisive action to fire the grievant when they in fact had not. This shows a demonstrable failure in the investigatory process leading to the discipline here that severely undercuts the objectivity requirement of any just cause based investigation.

12. The Union also disputed the assertion that the grievant “knew” what was in the resident’s care plan, Employer Exhibit 3, and noted that the care plan was not at the nurse’s station. In fact, it had been moved by the Pathways personnel to make certain notes on it. The pocket plan was specifically given to the staff so they would not have to look up the resident care plans in the book left at the nurse’s station. Thus the Employer’s argument that the grievant should have known the resident’s care plan based on its Exhibit 3 was simply not true.

13. The Union pointed out that the State investigated this incident and determined that the grievant was not guilty of neglect or abuse of this resident. The grievant still has her license, which she would have lost if there had been any determination of abuse or neglect by the State. While the Union acknowledged that the State’s determination is not necessarily binding on this tribunal it is of some value to note that the experts at the state whose job it is to determine whether a violation of State or Federal law or regulations, and presumably facility policy, occurred ruled that none occurred here.

14. The Union further argued that termination of this employee is far too harsh given the offense, even if there was an “offense” in this case. She has been with the Employer for approximately 20 years and has a good work record. The imposition of the supreme industrial penalty is simply unfitting for what occurred here.

Accordingly, the Union seeks an award sustaining the grievance, reinstating the grievant to her former position and to make her whole for all lost time and accrued contractual benefits.

DISCUSSION

There were no disputes about the facts that gave rise to the discipline even though there was considerable dispute about the underlying policy, notice to the grievant and whether there was lax enforcement of the Employer's policy and practices.

It was clear that on October 8, 2009 the grievant was caring for an elderly resident, known as resident 113W to protect her identity. Resident 113W was ambulatory but frail and needed a lift, known as an E-Z lift to position her and hold her in place while using the toilet.

It was undisputed that the grievant helped the resident to the bathroom and placed her in the lift while she used the toilet. It was also undisputed that the grievant then left her there unattended to go to the nurse's station to get a blood pressure cuff and the book to record those readings. She was gone for a "few minutes," although it was not completely clear from the evidence exactly how long. While the grievant was gone, an employee of Pathways, the consulting firm hired by the Health Care Center to assist it in coming into compliance with State and Federal regulations, found the resident alone in the lift and immediately called for a staff person to watch the resident while she found the grievant to ask why she had left the resident unattended.

The grievant admitted leaving the resident in the lift and indicated that she spoke to the resident and felt she was safe and would be safe for the few minutes she left her there. The Health Care Center filled out a report to the Minnesota Department of Health, MDH, as an incident of resident neglect. It was clear in this report that there was already an indication that the Health Care Center had terminated the grievant even though the evidence showed that the investigation had not been completed when this report was submitted.

The crux of the Employer's argument was that the resident's specific care plan clearly indicated that she was not to be left alone while using the toilet, even if she asked to be left alone. The actual care plan, Employer Exhibit 3 indicated as follows:

Resident does request not to be unhooked from stand-up lift while toileting. She should NOT be left hooked up. Give her the option either to have a walker placed in front of her or a stool for her feet, but don't leave her hooked up to the stand-up lift. She requests aides to stand outside of bathroom while toileting. Respect her dignity, but DON'T leave her alone with the e-z stand hooked up. (Emphasis in original)

The Employer argued that this could not have been clearer and that the grievant should have known from this that she was under specific and direct orders not to leave this resident alone, even if she "thought" the resident was safe.

On this question there was some merit to the Union's assertion that the grievant had not seen this care plan. In fact, as acknowledged by the Employer at the hearing and in its Brief, since the summer of 2009 the care plans were not at the nurse's station for the aides to review. This was done at the specific direction of Pathways in order to bring the Health Care Center into compliance with applicable State and Federal regulations. It was shown that in the past the aides had to run back constantly to the station to check on the care plans and this was not only highly inefficient but also somewhat dangerous in that patients were frequently left alone while the aide ran around doing this. The Employer's argument on notice based on the care plan itself might well have been persuasive if the grievant had the opportunity to see it but the evidence on this record showed that she did not. Accordingly, the assertion that the grievant had not in fact seen the language of the care plan found considerable evidentiary support.

However, the Employer also asserted that the grievant had with her a so-called pocket plan, i.e. a short summary of the residents' care plans that would also have clearly notified her that she was not to leave this particular resident alone. That document, which the evidence showed the grievant had with her, read as follows: "Do not leave her alone hooked up to the lift. Give her a walker placed in front of her or a stool for her feet." This, of course, closely mirrored what was in the specific care plan found at the nurse's station. The grievant indicated that she did not read this prior to October 8, 2009.

The Union argued that there is a discrepancy in the dates on this form; it is dated October 5, 2009. The evidence showed though that the document is re-done every day with any updates and that there may not have been any updates from October 5 to October 8, 2009. It was clear that the grievant should have reviewed this document to determine if anything had changed in the residents' condition, including this resident.

The Union further argued that the document occasionally includes residents who are gone or dead and that it leaves off people who should be on there. The Union asserted that the pocket plans contain other errors or omissions as well and that the form introduced as Employer Exhibit 4 may well have been missing that information about resident 113W as well. There was some evidence that this is the case but on this record it was clear that Employer Exhibit 4 *was* given to the grievant that week and that it *did* include information about resident 113W. There was no evidence that the form the grievant received was in error of that the form in evidence was "doctored" or inaccurate in a material way. Further, if the form had somehow left 113W off, it is curious that the grievant would have not known that then and questioned why 113W was not there. If that had in fact been the case, it would imply that the grievant did not pay much attention to the document at all and was certainly not a claim that benefited her case much.

One of the most hotly disputed issues was over whether the Employer had a clear policy against leaving residents alone in these types of lifts and if so whether there was such lax enforcement of that rule as to render it meaningless. The clear evidence showed that the employer did not have a general policy against leaving residents alone in the types of lifts used in this case. As noted by the Union, the Employer promulgated a policy after this incident in December 2009 but that of course was far too late to establish adequate notice to the grievant of a general policy against her actions.

The Union cited Elkouri as follows: “Arbitrators have not hesitated to disturb penalties where the employer over a period of time has condoned the violation of the rule in the past. Lax enforcement of rules may lead employees reasonably to believe that the conduct in question is tolerated by management.” Elkouri and Elkouri, *How Arbitration Works*, BNA 5th Ed at page 993. See Also, Elkouri and Elkouri, *How Arbitration Works*, BNA, 6th Ed at 994. Here the evidence was quite convincing that indeed even if there was once upon a time a rule against leaving residents in these lift, the clear and well-known practice was to ignore it.

Further, and significantly, this was not a practice engaged in by only the line employees with an occasional wink or some assertion of “constructive knowledge” by management. This was a practice engaged in by supervisory personnel routinely as well such that quite literally everyone, both line employees and managerial employees, were well aware of it. On these facts, the Union’s claim of lax enforcement was well supported by the evidence.

Further, and most significantly, the evidence showed overwhelmingly, that the general practice in this facility was that it was acceptable to leave residents alone in these lifts as long as the aide or nurse felt it was safe to do so. Even witnesses called by the employer acknowledged this and indicated that they would have left the resident in that lift as well if it had been them. This of course added greatly to their credibility since they would have been placing themselves at some risk of discipline if there indeed had been a policy against this.

Even supervisory personnel indicated that this was a common practice that the aides and licensed nursing staff performed routinely. The Employer put on no contravening evidence of this and the great weight of the evidence showed that the claim by the Employer that there was a general policy against leaving residents alone in these types of lifts failed due to insufficient evidence.

The Employer further argued that the policy against failing to follow resident care plans was clearly communicated to the staff at a meeting on August 5, 2009. The employer played a video of a manager indicating that she “hated” to have to fire someone for not following a resident care plan. It was also clear that the grievant was at that meeting at least for part of it. The Union claimed that she may have left the room for the short segment wherein the above statement was made and claimed that the tape does not show the grievant in the room. ‘The Tape did not show everyone in the room but it was frankly not designed to. The tape was of the person speaking, not the audience. Further, the grievant clearly signed in at that meeting and was therefore responsible for the information disseminated there. If she had missed something because she was out of the room it would have been her responsibility to find out what she missed.

There was also the question of whether the grievant had been disciplined before for this very type of activity – i.e. leaving a resident unattended. In support of this claim the employer argued that the grievant had been given discipline for this in 2006 and produced a document purporting to show a verbal warning for this. The evidence did not support the Employer’s claims here though. Further, the grievant did not recall even getting this document. She did not sign it and testified credibly that she never knew she had been disciplined for this incident. She further testified credibly that she was called to meet with the then Director of Nursing who asked her only why the resident in question in 2006 was screaming; no why she was in the lift by herself. The grievant testified credibly that she explained what happened and that the Director accepted her explanation without further action and that there was no discipline given or any sort of admonition not to leave residents in lifts.

Further, and significantly, *nobody* appeared to have signed it, including a supervisor. Moreover the person who supposedly gave the grievant this discipline was not called at the hearing leaving considerable doubt as to whether this was discipline at all.

Finally, the form attached to the “disciplinary notice” indicated that there were two aides involved in the incident referenced in 2006. The other aide involved in the 2006 testified credibly at this hearing that she was never disciplined in that time frame. These facts severely undercut the employer’s claim that there had been prior discipline for failure to leave a resident in a lift. More to the point, there was insufficient evidence on this record to even establish that the grievant had been admonished or coached not to do this. Her credible and unrefuted testimony was that the Director called her in to ask why the resident was screaming while in he lift and that there was no admonition of any kind against leaving her there and that the Director seemed satisfied with the grievant’s explanation of what happened in the 2006 incident.

There was considerable evidence of the context in which this incident occurred. It was clear that the Health Care Center was under close scrutiny from the State and that there was a very real threat that it could lose the ability to take Medicare eligible patients. That would have likely meant the closure of the facility. Accordingly, the Health Care Center was working very hard to fix whatever problems in record keeping and procedures necessary to come into compliance with all Federal and State regulations. The evidence showed that the Health Care Center reacted quite appropriately to the audit from the State regulators and that they hired a consultant to assist them in this endeavor.

There was evidence that the employer wanted very much to show the State auditors that it takes resident safety extra seriously and that the reaction to this incident may well have been jaded somewhat by this ongoing audit. While it was clear that the grievant left the resident alone, there was evidence that the reaction to that was jaded somewhat by the context in which this incident occurred.

At the end of the day, the question remains almost as the Employer asked it – whether the punishment fits the crime. The “crime” as it were, was that the grievant did not read the pocket plan carefully and realize that she should not have left this particular resident alone. That she had done so in the past was not relevant. That she left other residents alone was also not relevant. The pocket plan clearly showed that she should not have left her there unattended.

On the other hand, the Employer's claim that there was a policy against this was without any evidentiary support. It is abundantly clear that the general practice of leaving resident alone in these lifts was widespread and well known by the aides and management personnel. Thus even if there were such a policy its lax enforcement would easily have virtually negated it as of the time this incident occurred on October 8, 2009. It is axiomatic that just cause requires first and foremost that adequate notice of the rule and of the consequences of violating that rule must be communicated to the affected employees in order for the discipline to be sustained. Here it was not.

Further, while more time and energy is spent by parties on the investigation of discipline than is many times necessary, it is still clear that the employer must not make the decision to terminate people before conducting a fair and objective investigation. It must not in other words make the decision to discipline before even talking to the grievant and all those who have or may have relevant knowledge of the facts and circumstances giving rise to the discipline. Here that was not done either. The evidence showed that the form sent to MDH indicated that the grievant had been fired. This was before her actual termination meeting and severely undercut the claim that the employer conducted the type of investigation necessary to sustain a finding of just cause.

This case presented several pieces of evidence that mitigated in both directions here. On the one hand the Employer showed that the grievant failed to pay careful enough attention to the care plan in place for resident 113W. This could have led to a serious problem; not only because of the risk of slipping but also because of the risk that the resident could experience a health related problem while on the toilet. The result here should not be read under any circumstances as minimizing the need to watch constantly to ensure resident safety but on this record there was not enough evidence to support a termination.

Just cause requires a review of the grievant's actual misconduct; the overall record of discipline and the grievant's tenure with the Employer. Here when taking all the evidence into account there was insufficient evidence to sustain a discharge but there is some basis for discipline.

Several options were considered. Reinstatement with full back pay and benefits was rejected due to the grievant's clear failure to review resident 113W's care plan and her failure to watch her even though the resident appeared to be safe.¹ The record here demonstrates that while there was no general policy in place about leaving residents unattended, there was certainly a policy in place in pay attention to the resident's care plan. Indeed, that is part and parcel of the aides' jobs and the grievant clearly either missed this or ignored it. Either way, the resident care plan is not to be cavalierly overlooked.

Reinstatement without back pay or contractual benefits given the length of time the grievant has been out of work was also rejected. This would amount to a suspension of several months. Such a result is frankly too harsh given the determination that the grievant has in fact not been disciplined for this before, even though she does have some discipline for other matters. Arbitrators should be wary of imposing penalties or remedies without justifying why those penalties are being imposed. Certainly, on some records an award of reinstatement without back pay is appropriate, even where there are long lapses between the termination and the eventual award. While the grievant was guilty of a minor infraction her offense when compared to her long record did not warrant such a long suspension.

Upon a review of the entire record, the proven infraction, the lack of a clear policy and the lack of consistent enforcement of any policy against leaving residents in these lifts, the grievant's prior disciplinary record² and the grievant's long tenure with the Employer, is to reinstate the grievant with full back pay and accrued contractual benefits less a Five (5) day disciplinary suspension which is to be deducted from back pay and benefits. This of course is based on the grievant's long and relatively clean record and the overall record discussed above.

¹ It should be noted that the basis for the discipline was not and should not be based on whether there was or was not actual harm to the patient. The question is whether the patient was placed in risk of harm. An employer need not wait until a tragedy happens before taking appropriate action.

² The record did show that the grievant was given warnings in 1993 for being behind in her continuing education requirements, in 1998 for talking to her daughter on the phone and insubordination and in 2008 for a charting deficiency. The warnings given in 1993 and 1998 were frankly given very little weight since they were so old and the one from 2008 was given some weight but not much since it was for something so unrelated to the allegations here. See Employer exhibits 8, 9 & 10.

Further, the back pay award shall be subject to appropriate mitigation of damages, including any wages or salary earned, unemployment compensation or other government or private disability or wage replacement benefits paid to the grievant in the period between her termination and her reinstatement herein. The Union and the grievant are ordered to provide any and all appropriate documentation, authorizations and/or tax returns necessary to determine the amount of the back pay award ordered hereunder.

AWARD

The grievance is SUSTAINED IN PART AND DENIED IN PART. The grievant is to be reinstated to her former position with the Employer within five (5) business days of this Award with full back pay and accrued contractual benefits less a Five (5) day disciplinary suspension which is to be deducted from back pay and benefits, subject to mitigation of damages and provision of appropriate documentation as set forth above. The grievant's employment record shall be amended to reflect the Award herein.

Dated: February 25, 2010

IBT 160 and Adams Healthcare Center – Bergen award

Jeffrey W. Jacobs, arbitrator