

**ARBITRATION DECISION**

**IN RE**

St. Michael's Health & Rehabilitation Center  
Virginia, Minnesota

and

FMCS #06-53833-7

United Steelworkers, AFL-CIO, Local 9349

**DISPUTE:**

LPN Sue Ferrari termination.

Arbitrator:  
Daniel G. Jacobowski, Esq.  
November 1, 2006

**ARBITRATION DECISION - AWARD**

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DISPUTE: LPN Sue Ferrari termination.

**JURISDICTION**

APPEARANCES: Employer: Scott Allan, Labor Relations Consultant,  
Employers Association, Inc., Minneapolis.

Union: Tara Widner, USW Staff Rep, Minneapolis.

HEARING: Conducted on the day and evening of July 19, 2006 at  
the Coate's Hotel in Virginia, on this contract grievance,  
pursuant to the procedures and stipulations of the parties under  
their collective bargaining agreement. Briefs were received  
September 5, 2006.

**DISPUTE**

ISSUE: Did the employer have just cause for the discharge of  
grievant LPN Sue Ferrari? If not, the remedy?

CASE SYNOPSIS: The grievant was discharged on the grounds of  
failing to give proper response and treatment to an elderly  
resident, who exhibited choking and hard breathing symptoms in a  
night emergency, from which she died. The grievant was accused  
of violating professional nursing standards and of falsification  
of the records of the incident. The union claims lack of just  
cause.

CONTRACT PROVISION APPLICABLE:

SECTION 8. DISCIPLINE AND TERMINATION OF EMPLOYMENT

"8.4 Certain conduct is just cause for immediate  
termination. Such conduct includes, but is not limited  
to the following conduct:...

8. Falsification of employment records or of other  
Company records;...

10. Violation of the Resident's Bill of Rights, Minnesota Vulnerable Adults Act, or the Vulnerable Adults Policy;..."

#### **BACKGROUND - FACTS**

The grievant had been an LPN for 38 years, with 12 years at this facility. She was the night nurse supervisor, on the shift from 10:30 p.m. to 7:00 a.m. She primarily was in charge of the A wings, and another LPN serviced residents on the B wing, both joined together at the nurse's station.

The deceased resident who was the subject of this incident was an 89 year old vulnerable adult with a number of physical ailments, including being on oxygen, on kidney dialysis, a diabetic, legally blind, and with a recent leg fracture. She was on the grievant's A wing.

This incident occurred on early Thursday morning, September 22, 2005, shortly after 4:00 a.m. At that time both the grievant and CNA L were at the nurse's desk when they noticed the resident's call light on. The CNA went to check and found the resident in a serious condition saying that she was choking and couldn't breathe. The CNA raised her bed and then went to get the grievant. When the grievant arrived some minutes later and saw the resident from the doorway she immediately went to get a suction machine which was normally in the linen room across the hall. She couldn't find it and told the CNA she would go to the other LPN in the B wing where there was another suction machine. She then went to that LPN and obtained it. While talking with him the CNA came running to them with urgency for them to come quick because the resident was worsening and turning blue. Together the CNA and the B wing LPN, Y, ran back to the resident room where Y did a physical assessment, raised her higher in the bed, tried clearing her throat, found a weakening pulse but no heartbeat. While he administered to her he heard her last breath death rattle with her death. When the grievant came with the suction machine Y asked the grievant about CPR for the resident, the grievant didn't know or thought she was on the DNR list not to resuscitate. Seeing that the resident had expired, the grievant applied the suction machine to the resident, feeling she had to do something, but to no avail. Before going for the suction machine, the grievant did not do a physical assessment or check the vitals of the resident. By about 4:30 a.m. upon the death of the resident, the family was called, Y attended to the body of the resident, and the grievant returned to her normal 4:30 duties of making the rounds.

When the CNA and Y inquired what they should tell the relatives, the grievant responded to keep the story straight and simply say that when the call light came on and the grievant went to the resident's room, the resident had expired. On the resident chart the grievant simply noted that the resident had been sleeping

well all night and at 4:25 a.m. the resident's call light went on. Upon entering the room the resident had expired.

The company case. Later on September 22 and the days following, CNA L expressed her concerns to several others about what she regarded as negligence of the grievant with the resulting death of the resident. Informed of her concerns, the RN director of nursing gave directions for a full report of the incident and any other notes about the grievant and night supervision. On the following Monday, September 26, she was given supervisor reports of what CNA L had described as well as other notes of complaints and criticisms of the grievant in other instances of alleged disrespect to residents and staff. Upon reviewing the reports of the September 22 incident, the director determined that it appeared there was a violation of the Vulnerable Adults Act by the grievant and immediately acted to file a report to the Minnesota Department of Health on same. She also determined that a full investigation should take place and suspended the grievant pending the results of the investigation. On September 28 and 29 the nursing director and the social service director interviewed the key witnesses and other staff regarding the incident with statements or notes of their interviews, most of who also gave comparable testimony at the hearing. The three key witnesses to the incident were CNA L, the B wing LPN Y, and of course the grievant.

In describing the incident and the grievant response, CNA L also noted that the grievant made no physical assessment of the resident nor checked her vitals before going for the suction machine. She only viewed the resident from the doorway about 12 to 15 feet from the resident across the room. She and another witness stated that the grievant did not run but walked back with the suction machine. LPN Y stated that he did not initiate a CPR since the grievant was the responsible nurse in charge and he relied on her. Supervision and others stated that the resident was not on the DNR to not resuscitate and that her chart record of this was readily available nearby, which the grievant failed to check.

The grievant was interviewed on September 30. Among the notes of the meeting, by the time the grievant returned with the suction machine she thought the resident had expired but assumed she had been choking on phlegm and applied the suction machine anyway because she felt she had to do something. She admitted not putting all the details in the chart record feeling that a more detailed description of her condition might be upsetting to the family. She admitted not doing the CPR feeling that a suction was first needed because she had previously coughed up phlegm. She did not perform CPR because that would have taken time to check the record and then the resident was gone.

Upon review of the investigation interviews, the center concluded that the grievant was negligent in not immediately checking the vitals of the resident and making a physical assessment of her.

She failed to apply a CPR. She should have remained with the grievant instead of going for the suction machine, which either L or Y could have fetched. The response and conduct of the grievant violated the applicable standards of care and requirement contained in the Minnesota Nurse Practice Act, the Vulnerable Adult Act, the Policies and Procedures of the center, and her job description. In particular, she failed to fully document the incident and procedures as required, and made a falsification of the record. The grievant was fully knowledgeable of all of these provisions and attended periodic training sessions on them. As a result, the grievant was given notice of discharge on October 5, 2005. On October 10 the center submitted a complaint report on the grievant and her termination to the Minnesota Board of Nursing. Among additional details, it was noted that the grievant had received six discipline warnings in prior years. The administrator noted that the center did not investigate the other recent complaints of her conduct in other instances because it felt the September 22 incident was sufficiently serious to stand alone for the termination. The administrator noted disciplines and terminations given to others for falsification of records and negligent care.

In aftermath, the Department of Health took no further action since she was terminated. Likewise, the Board of Nursing took no further action against the grievant. Her claim for UC was denied for reasons of her misconduct.

The union case. The grievant described the incident as has already been outlined above. Among additional details, she explained she went for a suction machine since the resident had often coughed up phlegm before. She claimed she ran to and from the B wing for the suction machine even though she has sore feet which makes walking and running difficult. When she returned with the suction machine although she saw no movement and her no noise from the resident, she felt she had to do something and attempted to suction her. She had checked the resident earlier and found her okay. She did not check the CPR record because that would have taken time and she already thought her name was crossed off from a list at the desk. She was the only one who appeared before the Board of Nursing and they later sent a response of no action against her. She also made note that the place is very busy, that overtime has been discouraged, and that it's difficult at times to make appropriate chart records. However, she admitted not having much overtime in the past. She felt the brief record she noted on the chart was sufficient and did not want anything further noted to upset the family.

The unit chair verified the company's discouragement of overtime and the difficulties employees have had fulfilling their duties within the hours.

## **ARGUMENT**

EMPLOYER: In brief summary, the employer argued the following main points. 1. The grievant knowingly falsified work records. 2. She had proper notice and knowledge of the documentation required under the various acts and the employer's policies. She admitted falsifying the final record with the excuse to spare the family feelings. 3. The grievant had notice of termination and disciplinary action as provided in the collective bargaining agreement and the Nurse Practice Act, both documents of which she had knowledge. 4. Other employees have been disciplined and terminated for falsification. The grievant also had six prior disciplines in prior years. 5. The grievant failed to follow the resident care plan, the Nurse Practice Act, the Vulnerable Adult Act and the common standards of practice. The resident care plan was clear she wanted to be resuscitated. 6. The grievant violated the Nurse Practice Act in failing to do a physical assessment of the resident, by deciding to go for the suction, in failing to exhibit more urgency, and in applying a suction after death. Her conduct and response also violated the Vulnerable Adult Act and the employer's policies and procedures. 7. The grievant behavior was fully and fairly investigated with an opportunity given her for any questions, statements and with two union representatives present. 8. The termination was consistent with prior discipline actions. 9. Respectfully, the grievant cannot be trusted and the termination should be upheld.

UNION: In brief summary, the union argued the following main points. 1. A fair investigation of the incident was not performed. The Vulnerable Adult Act charge was filed after CNA L's statement initially given the nursing director. The grievant was not interviewed until 8 days after the incident. The investigation was tainted by CNA L who first talked with other staff, instead of directly reporting to upper supervision. She herself failed to make a mandatory VA report. The center interviewed others not directly involved but to whom L spoke. 2. The union was not properly notified initially of the suspension and charge to the grievant. 3. There are numerous contradictions between the testimony of L and Y on details of the incident. 4. Several on the staff are mandatory reporters under the VA Act but did not file a report. This includes L, Y and others to whom L talked. 5. The company claim of improper care in this incident is overstated. With the numerous physical problems of the resident, it is easy to understand why the grievant thought she was on the DNR list not to resuscitate. 6. CPR was not called for in this incident, based on the testimony of the grievant and Y. 7. The grievant did perform an assessment of the resident, by viewing her across the room and making the immediate decision of choking and the appropriateness of the suction machine close by. 8. The company claim of the grievant falsification of records is weak. It was not noted initially to her nor the union. She had never been warned of prior record keeping. With the company pressure to limit overtime, employees have difficulty finding time to chart records. L & Y did not make record of their

participation. The omission of the grievant of details and the record were for her compassion to family members.

9. The company failed to show a burden of proof. The grievant had 38 years as an LPN and 12 years with the company, with a good work history. No discipline was issued by the Minnesota Board of Nursing. 10. Respectfully, the termination was not justified, should be revoked, and a make whole remedy directed for the grievant.

#### **DISCUSSION - ANALYSIS**

On extensive review of the record and evidence in this case, I have come to the conclusion that the center was fully justified in its termination of the grievant. I so conclude based on the following reasons and factors.

1. The collective bargaining agreement clearly provides that falsification of records and violations of the Vulnerable Adults Act and policy are among items of just cause for immediate termination. The employer has adequately proven that the conduct of the grievant violated these provisions.

2. The response of the grievant to the resident emergency was established by the evidence and substantially admitted by the grievant. The main features were that she did not do an immediate physical assessment and check the vitals of the resident but instead made a brief observation from the doorway across the room. Her judgment to instead go for the suction machine was faulty and magnified by herself going forward instead of letting L or Y fetch it. She failed to apply CPR to the resident in her frenzied condition of her hard breathing and turning blue. Her application of the suction machine when it appeared the resident had already expired was not justified. The center has adequately proven that this conduct by the grievant violated the required standards of care required of nurses and the applicable statute and policies.

3. The excuses and defensive rationale of the grievant are inconsistent and not credible. Her claim of past recent phlegm by the resident does not excuse her conduct for the suction machine, and no condition of phlegm was noted in the resident chart. Her failure to apply a CPR because it would take too much time to check the record of the resident wish and that her name had been crossed off the resuscitation list is inconsistent with the evidence otherwise. Her claim that she ran to and from the suction machine is inconsistent with the testimony of L and another employee who saw her. Rather the evidence was that she did not display a sense of urgency in the incident.

4. The evidence clearly establishes that the applicable statute and policies require a full complete documentation of the incident, the resident condition and the treatment given with those in attendance. By her own admission the grievant failed to

so document the record. In fact the simple statement she did record was deceitful in addition to the omission of details. Her claim of compassion for the family is no excuse to the obligation of this requirement.

5. I have reviewed the various other defensive claims of the union but find that they are not persuasive, are inconsistent with the evidence, and do not overcome the substance of the main charge proven that the grievant was guilty of improper response and care to the resident and was guilty of falsification of the records.

#### **DECISION**

The employer had proven just cause for the termination of the grievant. The discharge is sustained. The union grievance is denied.

Dated: November 1, 2006

Submitted by:

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Daniel G. Jacobowski, Esq.  
Arbitrator