ARBITRATION DECISION NO.:
14

UNION:
OCSEA, Local 11, AFSCME, AFL-CIO

EMPLOYER:
Department of Mental Retardation and Developmental Disabilities

DATE OF ARBITRATION:

DATE OF DECISION:
March 30, 1987

GRIEVANT:
Jeraldine Jones

OCB GRIEVANCE NO:
G-86-0328

ARBITRATOR:
Frank A. Keenan

FOR THE UNION:
Daniel Scott Smith Legal Counsel

FOR THE EMPLOYER:
Laurel D. Blum Assistant Attorney General

KEY WORDS:
Progressive Discipline
Resident Abuse
Failure of Good Behavior

ARTICLES:
Article 24 – Discipline
§24.01 – Standard
§24.02 – Progressive Discipline
§24.03 -
§24.04
§24.05

Article 25 – Grievance Procedure

FACTS:
The Grievant was employed at the Apple Creek Developmental Center as a Licensed Practical

Nurse (L.P.N.) for twenty (20) years. Grievant was removed in August, 1987 as a result of a charge of resident abuse and failure of good behavior.

The Center maintains rules and policies with respect to the administration of medications to the Center's clients. Resident abuse has been defined as any act or absence of action inconsistent with human rights which results in physical injury and/or emotional duress to the resident. A specific example of resident abuse set forth in the policy is: the unauthorized use of medication which has not been authorized by an M.D. or D.O., or inappropriate use of medications by a physician. Grievant was found guilty of distributing an overdosage of medication to clients, which resulted in her removal.

EMPLOYER'S POSITION:

It is management's contention that it maintained a clear policy proscribing resident abuse and that the Grievant was well aware of this proscription. Grievant engaged in conduct which clearly constituted resident abuse. Management points to Section 24.01 of the contract, and maintains that the Arbitrator is without the authority to modify its termination of the Grievant, based on her abuse of a patient, and this is so despite her otherwise excellent employment history.

UNION'S POSITION:

The Union contends that the burden of proof of management must be substantially higher than a mere preponderance of the evidence. Therefore, the agency has failed to meet its burden of proof. The Union urges that there is no persuasive evidence that the extra medications were in fact dispensed by the Grievant. Additionally, the Union contends that there is no evidence of harm to the residents, and the Agency's own definition of resident abuse incorporates harm as a requisite element of such. Finally, the Union states that since no patient abuse is made out, the constraints on the Arbitrator's authority to modify the Agency imposed penalty of discharge, Section 24.01, are inapplicable here. The Arbitrator has the authority to "modify" the penalty of termination.

ARBITRATOR'S OPINION:

The Arbitrator found that conduct such as that at issue in this case ought to be reviewed according to a higher standard of proof. Therefore, management must establish clear and convincing evidence of patient abuse by the Grievant. Management has established clear and convincing evidence that the Grievant intentionally set-up overages of medication through circumstantial evidence and the testimony of fellow employees.

As the Union points out, there is a lack of evidence that any client experienced the symptoms of overdoses. Under the Agency's own definition of resident abuse the actual administration of improper amounts of medication is required to establish and meet the requirements of resident abuse. Therefore this element of the case has not been established by clear and convincing evidence. The evidence indicates that improper amounts of medication were not administered by the Grievant. Nor is there any clear and convincing evidence that the Grievant ever administered extra medications in the past.

The Arbitrator concluded that no case of resident abuse was made out and hence the strictness of section 24.01 concerning modification of the penalty of termination is inapplicable. There is no doubt that the Grievant's offense was a grave one. Nonetheless her long and unblemished record of service serves to mitigate her offense.

AWARD:

The Grievant is to be reinstated to her former position without loss of seniority, but without back

pay.

TEXT OF THE OPINION: * * *

Arbitration

Between

The State of Ohio,
Department of Mental Retardation
and Developmental Disabilities
(Apple Creek Developmental Center) OCB GR. NO. G-86-0328

and

Jeraldine Jones

Ohio Civil Service Employee Association,
Local 11, A.F.S.C.M.E., AFL-CIO

OPINION AND AWARD OF THE ARBITRATOR

Frank A. Keenan
Panel Arbitrator

* * *

Appearances:

For the Agency:

Laurel D. Blum
Assistant Attorney General

For O.C.S.E.A.:

Daniel Scott Smith
Legal Counsel * * *

I. The Contract:

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Relevant contract provisions include all of Article 24 and 25, and in particular Section 24.01 - Standard, which provides in pertinent part as follows:

"Disciplinary action shall not be imposed upon an employee except for just cause. The Employer has the burden of proof to establish just cause for any disciplinary action. In cases involving termination, if the arbitrator finds that there has been an abuse of a patient or another in the care or custody of the State of Ohio, the arbitrat6r does not have authority to modify the termination of an employee committing such abuse."

II. The Grievance:

The grievance states in relevant part as follows:

"What Happened (state the facts that prompted you to write this grievance)?

I, Jeraldine Jones, grieves Management is in violation of Articles 24, Section 24.01, 24.02, 24.03, 24.04, and 24.05. And all other pertinent articles and sections of the OCSEA/AFSCME contract and the Ohio Revised Code. And makes such claim when on September 10, 1.986, I received per memo from Director of MR/DD that I was being removed for failure of good behavior and resident abuse. (For on or about 7/25/86 my immediate supervisor Arlene Yoder R.N. supposedly discovered an unauthorized dosage of Senokot-S contained in the medicine cart of which I set up, but Ms. Yoder failed to bring any "Med" error if one was actually made to my attention that day. A report was filed 5 days after the supposed incident by the R.N. to Security.) Not until 4:25 p.m. on July 30th, 1986 was I ever made aware of any supposed error made on my part in dispensing resident medication. And on this date security began to question me of an incident that I was not knowledgeable of.) I, Jerry Jones, am requesting that this discipline of removal be expunged from my records and that I be made fully whole.

The parties stipulated that the grievance is properly before the arbitrator.

III. The Evidence

The Apple Creek Development Center is a live-in facility for the severely and profoundly retarded. As the parties stipulated, the Grievant was employed at the Center as a Licensed Practical Nurse (LPN). The Grievant was removed, effective August 26, 1986, because, as her Order of Removal recites, she'd been found " . . guilty of failure (of) good behavior (and) resident abuse in the following particulars, to wit: On or about 7-25-86, you set up and dispensed unauthorized doses of Senokot-S to residents of Module 18." As the parties further stipulated, "the Grievant, until her removal, was employed at ACDC continuously since January 8, 1967; the Grievant has no prior discipline."

As with all LPNs, the Grievant's duties consisted of various activities designed to assist and care for the resident clients of the Center, including the preparation and distribution of client's medications. Another duty is to administer enemas when such is required.

The Center maintains rules and policies with respect to the administration of medications to the Center's clients. of particular relevance here is Apple Creek Developmental Center Operational Directive G-9 proscribing "resident abuse." Paragraph IV. defines "resident abuse" as "any act or

absence of action inconsistent with human rights which results in physical injury and/or emotional duress to a resident." Specific examples of "resident abuse set forth in this policy includes: "4. Unauthorized-Use of Medication - Any use of medications which

has not been authorized by an M.D., D.O. or inappropriate use of medications by a physician, shall be considered resident abuse. Examples: . . . unauthorized adjustment of correct dosage." Another example provides: "7. Aggravation of Abuse - Any withholding of knowledge concerning an incident of alleged abuse and/or aggravateen [sic] of said abuse shall be considered resident abuse. Examples: Failure to report a suspected act of resident abuse." The record amply demonstrates that through in service training, the Grievant knew or ought to have known the Center's resident abuse policies and the potential for discharge for violation of those policies.

On July 25, 1986, the Grievant was assigned to prepare and distribute medications to some sixteen clients on module #18 in Jonathan Hall. On this date, and indeed usually, the Grievant was working under the immediate supervision of Registered Nurse Arlene Yoder. Several of the clients on Module #18 had prescribed for them certain dosages of the laxative Senokot-S. Others were not prescribed any Senokot-S. Senokot-S is kept in the clinic area in bulk in jars. Accordingly, RNs, LPNs, and other Center personnel have ready access to such. Senokot-S is a bright orange tablet.

As per her assignment, the Grievant prepared the medications (meds) for module #18 in the clinic area for Jonathan Hall on the morning of July 25, 1986. She then left to administer meds on module #12. When she did so, she left in the clinic area the set-up med cart for Module #18. While the Grievant was gone

from the clinic and administering meds to Module #12, LPN Anne Marie Heilman remained in the clinic along with RN Yoder. One of the residents on Module #18, Nancy Tanner, was due to leave the facility for some instruction, and so came by the clinic to receive her medication. RN Yoder went to the Module #18 med cart, intending to get and administer to resident Tanner her medications. When she opened the compartment on the medicine cart for Module #18 reserved for Tanner, she observed that there were "extra" Senokot-S tablets. In this regard RN Yoder from time to time assumed responsibility for the distribution of medications on Module #18, and hence had some familiarity with Tanner's medications. Yoder called LPN Heilman over to the med cart and asked her if the dosage of Senokot-S in the small cup for Tanner was correct. Heilman, who also occasionally administered meds to Module #18, believed it was incorrect. Heilman and Yoder then checked the chart for Tanner and other clients on Module #18. A cross-check, in Heilman's presence, with the actual amount of Senokot-S in Tanner's, and other clients, cup in their respective compartments and their charts, revealed that several clients for whom Senokot-S was prescribed had more Senokot-S then prescribed in their cup; other clients who were not prescribed Senokot-S, had Senokot-S in their cup; still other clients, described by Heilman as alert, and as clients who would know if they were receiving an addition to their normal dosage of Senokot-S, had no Senokot-S in their cup. Later in the day, at lunch time, LPN Heilman fortuitously ran into RN Heath, a Jonathan Hall supervisor, and related to Heath

that overages of Senokot-S had been found that morning in the med cart for Module #18, which had been set up by the Grievant. Heath in turn reported the matter to the Director of Nurses, Carol Moustaris, on July 29, 1986. An investigation ensued. In the course of the investigation LPN Heilman gave the following unsworn statement:

> "On Friday the 25 of July Arlene, me and Jerry were working A Clinic. A min.(ute) after Jerry had left to pass Mod 12 medication Arlene said look at these cubicals--I observed a lot of extra Senokot-S tabs in cart. A lot more than ordered. (Module #18) Jerry had set up these medications along with Mod 12. 1 did Module 14 + 16. Mary Pope, M. Rooney, Novkov are the only residents I noticed didn't have Senokot-S tab in it. Absolutely nobody else was present in the Clinic when medications were set up in a.m. but Arlene, Jerry and I. The one thing that stood out in my mind was Carl Flory who gets no Senokot-S had 5 or 6 in medicine cup."

Asked what pos,sible rea-son extra Senokot-S might be given by an LPN, Heilman indicated they might be given to avoid having to administer enemas, as indicted above, an LPN responsibility. On the other hand Heilman also indicated that diarrhea, a possible consequence of too much Senokot-S, created extra work, principally for nurse aides, and to a lesser extent for LPNs.

Heilman also testified that RN Yoder "played games" and was a jokester. Heilman indicated that Yoder's games and jokes were 19not serious," and that she doubted that Yoder would do anything to get an employee into serious trouble.

Yoder, who did not testify, [1] gave the following unsworn statement on July 30, 1986, in the course of the Center's investigation:

"7-30-86

> I had to get meds out of a med drawer for a resident who was leaving for school off the hill. I noticed this resident, N. Tanner had too many laxative pills. I removed the extra ones. I then checked other med drawers and saw there were other residents receiving too many Senokot-S tablets. I did talk with Ms. Jones LPN about the extra pills and asked that she not give any extra ones. She said none of them got enough and could use more.
>
> I did witness Jerry Jones LPN setting up the meds for this med cart (Mod 18).
>
> Q. About what time was Ms. Jones setting up the medications?
>
> A. Around 7:00 a.m.-8:00 a.m., this was on Friday, 7-25-86.
>
> Q. How do you know there were too many Senokot-S laxative tablets

dispensed?

A. I set the meds up for that module (18), frequently .and I know how many are put out. -There are two people who get 3 tablets. The others, that it is ordered for get one or two, you have to check the med order by the Doctor as to the set up.

Q. How many tablets were in the med cups over the ordered amount?

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[1] Yoder went on disability leave on September 17, 1986, due to stress. She has never returned to the facility. In the opinion of Nursing Director Moustaris, Yoder failed to return to work because she anticipated she too would be disciplined. The Agency requested, and was given, a subpoena for Yoder to testify at the arbitration. The record fails to disclose whether service was attempted and if so, whether it was accomplished. No request for adjournment pending judicial enforcement of the subpoena was made.

A. Some had 2 over, some 3 over, one resident who didn't get any had four in his med cup- The resident was Carl Flory that had the 4 Senokot-S tablets in his cup. The other residents that I can remember that had over amounts of Senokot were Keith Conley, Richard Cook, Perry Evans, Tony Salamone and numerous others. I can't remember, generally any resident who got the Senokot had extra tablets in these med cups.

Q. Do you have anything else to add to this statement?

A. No.

Additionally, it was Nursing Director Moustaris' testimony that Yoder advised her, Moustaris, that the giving out of extra medications by the Grievant had happened before and that she, Yoder, had talked to the Grievant about it. According to Moustaris, when she, Moustaris, asked Yoder concerning to whom she reported these matters, Yoder indicated that she had not reported them, but that she had warned the Grievant on these occasions. in this regard it is noted that Moustaris conceded that she, Moustaris, at some point got the impression that Yoder was simply trying to cover for herself. Moustaris also conceded that Yoder indicated that the Grievant's past incidents of giving out extra medications that she, Yoder, had referred to, could have been as a result of a mistake.

Moustaris also testified that Yoder had told her that she had-removed the "extra" Senokot-S from some of the residents, cups but that she wasn't sure that she had gotten them all. Asked if she, as an RN, would have let the module #18 med cart go out on the floor for distribution with wrong medications on it, Nursing Director Moustaris testified that she would not have done so.

Moustaris also indicated that up until July 25, 1986, an RN such as Yoder did not normally check an LPN's preparations of medications albeit they did so occasionally, and hence an LPN would not know when such a check might be conducted. Since

July 25, 1986, RNs check an LPN's preparations of medications once a week.

The Grievant was also interviewed on July 30, 1986. The interview was conducted by Security Chief Ross Davison and attended by Nursing Director Moustaris and Union Steward George Brown. It was Nursing Director Moustaris' account that just prior to the interview the Grievant asked her what the big deal was, that the allegation only involved a laxative and that she, the Grievant, had never given out extra tranquilizers.
Moustaris also testified that the Grievant stated that "we've all given meds without doctor's orders."

During the Grievant's interview by Security Chief Davison, Union Steward Brown took notes. Both Moustaris and the Grievant indicated that Brown's notes were accurate. They follow: 7-30-86 - 4:25 p.m.

I was called to questioning of LPN Jerry Jones.
Accused of giving too much meds to resident.

People present - Ross Davison - security chief.
Jerry Jones - accused.
Carol Moustaris - Director of Nursing.
George Brown - Union Rep.

At 4:40 p.m. Miss Jones was given her rights which she waived and stated she would answer questioning at that time she signed waiver. Allegations were filed by LPN's Unit RN A. Yoder. **8**

Charges of Allegation

Giving a resident too much laxative on 7-25-86 1st shift name of laxative--Senokot-S which is also a stool softener.

"Questions" by Security

Q1. Did you set up meds at unit A clinic on Friday 7-25-86?

A. Yes.

Q2. About what time did you set meds that morning?

A. Between 7 & 8 a.m.

Q3. What mods did you set up that morning?

A. You told me 12 and 18. Don't you remember? No; I am a wreck right now.

Q4. Jerry did you pass meds that day?

A. Yes.

Q5. Where did you pass the meds?

A. Mod 18. Hallway in front of clinic.

Q6. Do you remember passing meds to mod 18?

A. Right now I don't remember.

Q7. Who comes to get meds in hallway in front of clinic?

A. Mods 16 -18.

Q8. Where does mods 12 and 14 get meds?

A. Mostly dining room, but sometimes on these mods.

Q9. Who set up meds on day of question?

A. Ann set up mod 14 and 16. 1 set up mod 12 and 18.

Q10. Jerry, what is Senokot-S?

A. Stool softener and laxative.

Qll. Did you give overages of Senokot-S to any residents' med setup on said Friday?

A. Not to my knowledge

Q12. Have you ever?

A. I suppose I have.

Q13. Is that a Yes or No?

A. Yes.

Q14. When?

A. I don't know (it could have been a couple of months ago). (Someone pointed out.)

Q15. Did you do it on Friday 7-25-86?

A. Not to my knowledge.

Q16. Do you think you could have done it by mistake?

A. Anything is possible. The way we are rushed at Unit A.

Q17. Is this statement true to the best of your knowledge?

A. Yes.

"Questions by Carol-Moustaris"

Q1. Do you feel our residents don't get enough laxatives?

A. I think our residents on wheel chair mods should be watched more carefully. Because in the last couple of months we have given more fleet enemas than in the past.

It was the Grievant's testimony that on July 25, 1986, she did not set up and dispense any extra Senokot-S tablets to Module #18 clients. It was further the Grievant's testimony that on only one occasion, and that due to a mistake, did she ever dispense extra medication. As the Grievant elaborated, a resident client's medication dosage had been reduced by the attending physician and the Grievant initially failed to notice the change in dosage. The **10**

Grievant caught her mistake herself. The Grievant also denied that RN Yoder had confronted her on July 25, 1986, or indeed had ever in the past spoken to her, concerning dispensing too much laxative.

The Grievant asserted that she was "set up," albeit she fell short of directly accusing Yoder of doing so, contending only that it had to have been someone in the Center's employ who had access to the Clinic where her med cart for Module #18 was located, such as RNs, LPNs, and pharmacy personnel, but conceding that she had no "proof." It is clear, however, that the Grievant meant to infer that Yoder had set her up. Asked on cross-examination why if she were set up, Yoder did not report it, the Grievant responded that perhaps Yoder had bigger things in mind, namely, a “set up" for overages of narcotics. According to the Grievant, Yoder, with some frequency, observed that the Grievant had worked at Apple Creek long enough, and indeed, shortly before she was questioned on July 30, 1986, Yoder told her to "watch it"; that maybe somebody thinks that you've worked here long enough.

The Grievant also testified that someone was playing games with the meds "on and off."

Finally it is noted that Yoder consistently gave the Grievant good employee evaluations and ratings. **11**

IV. The Parties' Positions:

A) The Agency:

The Agency takes the position that it maintains a clear policy proscribing resident abuse and that the Grievant was well aware of thi8 proscription. The Agency further contends that the Grievant engaged in conduct which constituted unauthorized use of medications which conduct clearly constituted resident abuse.

No credence can be given to 'the Grievant's "set up" defense, asserts the Agency. Thus the Agency asks rhetorically, if Yoder was out to set up the Grievant, why did she fail to report the events of July 25, 1986, to management? Furthermore, argues the Agency, Yoder's high evaluations of the Grievant belie any motive to "set up" the Grievant and cause her dismissal.

Pointing to the contract's express provisions restraining an Arbitrator from modifying the Agency determined penalty for resident abuse set forth in Section 24.01, the Agency contends, that the Arbitrator is without authority to modify the Agency's termination of the Grievant, based as it is on her abuse of a patient, and this is so despite the Grievant's "otherwise excellent employment history."

Based on all the foregoing the Agency urges that the grievance be denied.

B) The Union:

The Union takes the position that the burden of proof the Agency must meet here is substantially higher than a mere "preponderance" of the evidence, and that, in any event, the Agency has failed to meet its burden of proof. In this regard the

Union contends that the Agency's case against the Grievant is based principally on the hearsay statements of Yoder, who did not testify and hence was not subject to the rigors of cross-examination. In contradistinction.the Grievant, who did testify,
and was subject to the rigors of cross-examination, emerged as a most credible witness. In any event, urges the Union, there is no persuasive evidence that any extra medications were in fact dispensed by the Grievant on July 25, 1986. But such evidence is essential to making out a case of resident abuse against the
Grievant, argues the Union. In a similar vein it is the Union's contention that there is no evidence of harm to the residents, but the Agency's own definition of resident abuse incorporates a requisite for harm in defining what constitutes "resident abuse"
This being so, argues the Union, no resident patient abuse is made out, and hence the constraints on the Arbitrator's authority to modify the Agency imposed -penalty of discharge, set forth in Section 24.01, are inapplicable here, and the Arbitrator,
therefore, does have the authority to "modify" the penalty of termination.

Based on all the foregoing, the Union urges that the grievance be sustained.

V. Issue:

The parties have stipulated that the issue is:

"Was the Grievant removed for just cause? If not, what shall the remedy be?

VI. Discussion and Opinion:

As a logical starting point, I note with approval the Elkouri's observation in their learned arbitration treatise:

> There are two areas of proof in the arbitration of discharge and discipline cases. The first involves proof of wrongdoing; the second, assuming that guilt of wrongdoing is established and that the arbitrator is empowered to modify penalties, concerns the question of whether the punishm29t assessed by management should be upheld or modified.[2]

Under Article 24, Section 24.01 of the parties' contract, however, the parties have in effect confined the inquiry to the first area of proof, proof of wrongdoing, when the "wrongdoing" alleged is patient abuse.

> And as the Elkouris further observe:
>
> An Arbitrator may require a high degree of proof in one discharge case and at the same time recognize that a lesser degree may be required in others. Similarly, where the proof was not strong enough to support discharge, some arbitrators have nonetheless found it strong enough to justify a lesser penalty.

Further with respect to the quantum of proof required, in an oft cited decision, Kroger Co., 25 LA 906 (1955), Arbitrator Russell A. Smith appropriately observed at page 908 that:

> It seems reasonable and proper to hold that alleged misconduct of a kind which carries the stigma of general social disapproval as well as disapproval under accepted canons of plant discipline should be clearly and convincingly established by the evidence. Reasonable doubts raised by the proofs should be resolved in favor of the accused. This may mean that the Employer will at times be required, for want of sufficient proof, to withhold or rescind disciplinary action which in fact is fully deserved, but this kind of result is inherent in any civilized system of justice.

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[2] How Arbitration Works, Elkouri & Elkouri, 4th Edition, 1985, BNA Books, Inc., Washington, D.C., p. 661.

In my view to be added to the concept expressed by Arbitrator Smith is the notion that conduct which in the particular career of the accused, represents in effect the "kiss of death" for prospects of continued employment in their chosen field, such as the conduct of alleged patient abuse vis a vis the health care industry, ought also to be established by clear and convincing evidence, and I so find.

Finally it is noted that while hearsay is generally received in arbitration and "taken for what it is worth," it generally is accorded little to no weight in discipline and discharge cases, with exception, to be sure, in circumstances which tend to corroborate the hearsay evidence.

Applying the foregoing principles to the evidence at hand, I am not persuaded that the evidence against the Grievant - I concerning her setting up of extra Senokot-S for residents of Module #18 is based primarily on the hearsay statements of RN Yoder. To the contrary "circumstantial evidence" combined with the eye witness observations of LPN Heilman constitute formidable evidence, indeed "clear and convening" evidence, that the Grievant intentionally set up overages of Senokot-S. The number of residents whose cups contained extra Senokot-S belie any contention that the extra medications were merely an oversight or mistake, as in the one prior incident of mistake which the Grievant concedes. And any doubt in this regard is in my view laid to rest by the circumstances of the omission of any medication for those residents who were alert enough to recognize any extra medication. That extra medications were in the Module

#18 med cart is clearly established by the credible testimony of LPN Heilman who physically observed such. Moreover, the Grievant concedes that she set up the medications for the Module #18 med cart on July 25th. Her implication that RN Yoder, or some other employee, planted extra Senokot-S is not credible in view of the circumstances as set out in Heilman's statement to the effect that the extra medications were discovered but a minute after the Grievant first left the med cart iinattended to go distribute meds in Module #12, an insufficient amount of time for Yoder, or any other employee to "plant" the extra Senokot-S tablets in the number of cups involved here. Then too there is a "motive" to administer extra laxatives and that is the avoidance of the doubtless unpleasant task of having to administer enemas.

The evidence with respect to the actual distribution of these extra Senokot-S tablets stands on a different footing, however. This, it is clear from Heilman's testimony that each patient's cup was checked, as was each patient's chart. In my view, Yoder's hedging to the effect that perhaps she failed to remove all the extra laxatives was more likely simply an expression of caution in the event it developed that nonetheless some Module #18 patients experienced the kind of symptoms and problems resulting from overdoses of laxative, such as cramping and diarrhea. In my view it is far more reasonable to rely on the probability of Yoder's professionalism and nursing ethics as motivating her, as it would have motivated Director Moustaris, to remove all the extra laxative from the residents' cups and to conclude then indeed all were in fact removed, and I so conclude.

As the Union points out, this conclusion is bolstered by the lack client of evidence that any Module #18/experienced the symptoms of overdoses of laxative on July 25th, evidence of which was presumably readily available by way of the resident's medical history records.

But under the Agency's own definition of patient or resident abuse, the actual administration of improper amounts of medication is required in order to establish and meet the Agency's definition

of "resident abuse." Thus this element of the case has not been established by "clear and convincing" evidence. To the contrary, the evidence indicates that improper amounts of laxative were not administered by the Grievant on July 25th.

Nor is there any clear and convincing evidence that the Grievant ever administered extra medications in the past. Thus Yoder's indication that the Grievant had done so is virtually totally undermined by Director Moustaris' concession that Yoder's reference was evidently to past "mistakes" and by Moustaris' concession that in any event Yoder's credibility with her was suspect because she was left with the impression that much of Yoder's assertions were simply born of a desire to save her own skin to avoid the imposition of discipline on her. As Example 7 of Agency Policy G-9 indicates, Yoder's purported apprehension of forthcoming discipline for herself was not unfounded. Moreover, this conclusion is not undercut by the Grievant's assertion to Moustaris' to the effect that we've all done this before, because this assertion simply indicates that others besides herself, had engaged in similar conduct.

In sum then, no case of resident abuse is made out and hence the strictures of Section 24.01 concerning modification of the penalty of termination is inapplicable. What is established then is the offense, certainly closely akin to "resident abuser of setting up extra medications which could well have led to patient abuse. The distinction to be made is that perhaps the Grievant would have had second thoughts when it came to actual administration of the extra laxative. The Grievant's long unblemished record of service lends credence to this possibility.

In conclusion, there can be no doubt but that the Grievant's offense was a grave one. Nonetheless her long and unblemished record of service, not only to the State, but to the employing institution, serves to mitigate her offense. This being so the Grievant is to be reinstated to her former position and without loss of seniority, but without back pay. I am satisfied that this disposition of the matter will serve to impress upon the Grievant that indeed the setting up of extra laxative medications is a "big deal," and that, as to be expected from the fact of the Grievant's long and unblemished service, she will henceforth conscientiously adhere to the Center's policies concerning patient care.

Award

The grievance is sustained in part and denied in part. Grievant is to be reinstated without loss of seniority, but without back pay.

Dated: 3/30/87

Frank A. Keenan
Panel Arbitrator

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