STATE OF IOWA
BEFORE THE PUBLIC EMPLOYMENT RELATIONS BOARD

AARON COLE, Appellant, and STATE OF IOWA (DEPARTMENT OF HUMAN SERVICES), Appellee.	)	CASE NO. 102113

DECISION ON REVIEW

This case is before the Public Employment Relations Board (PERB or Board) on Appellee State of Iowa's petition for review of a Proposed Decision and Order issued by an administrative law judge (ALJ) following an evidentiary hearing on Aaron Cole's section 8A.415(2) State employee disciplinary action appeal. Cole was a Resident Treatment Worker at the Iowa Department of Human Services' Glenwood Resource Center since 2000. The State terminated Cole's employment for his alleged treatment of an adult dependent resident.

In her Proposed Decision and Order issued June 27, 2019, the ALJ concluded the State of Iowa had not established just cause for its termination of Cole's employment with the Department of Human Services (DHS) on August 24, 2017. The ALJ concluded the imposition of a three-day suspension was warranted under the totality of circumstances. The ALJ ordered Cole's reinstatement to his former position at Glenwood Resource Center (GRC) or, if the position did not exist, to a substantially equivalent position with back pay and benefits, less interim earnings and other deductions associated with a three-day suspension.

Attorney Alla Minter Zaprudsky for the State and AFSCME representative Julie Abel for Cole, presented their oral arguments to the Board on November 26, 2019. Prior to oral arguments, the parties filed briefs outlining their respective positions.

Pursuant to Iowa Code section 17A.15(3), on review of the proposed decision, the Board possesses all powers that it would have possessed had it elected to preside at the evidentiary hearing in the place of the ALJ.

Based upon our review of the record, as well as the parties' briefs and oral arguments, we adopt the ALJ's findings of fact with additions and we adopt the ALJ's conclusions with additional discussion for the basis of our determination. We agree with the ALJ's conclusions. The State failed to establish just cause supported its termination of Aaron Cole's employment, but just cause existed to support a three-day suspension. We make the following findings of fact and conclusions of law.

FINDINGS OF FACT

The ALJ's findings of fact, as set forth in the Proposed Decision and Order attached as "Appendix A," are fully supported by the record. We adopt the ALJ's factual findings as our own, with the following additions and discussion:

During oral arguments, the State indicated that it did not dispute any of the factual findings, but disputed what it characterized as the ALJ's application of her findings to the law: that Cole raised his foot to block resident DW's movement from the room rather than intentionally "kick" him; that Cole needed to confine DW to his room; and, that Cole was truthful in the GRC investigation. We think these are matters addressed in the ALJ's findings although they

certainly affect the ultimate conclusions. We give weight to the ALJ's credibility determinations on her related findings and agree that the evidence supports each.

The incident occurred on January 27 when Cole was in charge of dependent adult resident DW and attempted to restrict DW's movement from the room because DW was not fully clothed. We disagree with the State that more weight should have been given to Anders' version of Cole's interaction with resident DW. In resolving the factual dispute of whether Cole, while seated, raised his foot to block DW's forward progress or intentionally "kicked" DW, the ALJ reviewed other evidence in the record. Specifically, the ALJ noted that Cole's extended foot was flat, not pointed, at the time of contact. The contact was not strong enough to cause DW to stumble or fall and a full medical assessment did not reveal any visible marks or bruises on DW. Cole acknowledged his foot made contact with DW and that his attempt to block DW is inconsistent with the Mandt techniques and training he received.

Further, we reiterate the ALJ's determination that the record as a whole does not establish that Cole's intent in extending his foot was to "kick" DW. Cole's stated reason for extending his foot, to keep DW inside the room when he was not fully clothed, is consistent with other facts. The State did not dispute the finding that "staff is to direct [DW] to his bedroom or other private area" when he is not fully clothed. Investigator Jason Sells testified that DW "had his shirt off" at the time of the incident. Thus, as the evidence reflects, Cole was required to direct DW to remain in his room when this incident occurred. Despite the

State's contrary assertion, Cole's stated purpose for lifting his foot to block DW is supported by the record.

Additionally, there is no evidence to suggest that Cole would intentionally kick a resident. The undisputed facts reflect that Cole maintained a calm and appropriate demeanor when supervising residents with very challenging behavioral issues. We also agree with the ALJ's rationale in finding the "timing of Cole extending his foot, coupled with the short distance between him and DW, support a finding that his intent was only to block DW's exit from the bedroom using his foot, not to intentionally 'kick' DW." To us, it is not plausible that Anders, coming down the hallway, saw Cole get up, out of a chair with rollers, lift his leg and intentionally "kick" DW.

Finally, we disagree with the State's last contention that Cole's agreement to the Consent Order was an admission of guilt and he was not truthful in the GRC investigation as a result. This order provided in part that the Department of Inspections and Appeals' (DIA) report regarding dependent adult abuse would be amended to confirmed, not registered. In determining that the order was not Cole's admission of guilt and the ALJ was correct in finding Cole truthful, we make several additions to the findings relevant to this issue and to our conclusions.

Training conducted by DIA included "Dependent Adult Abuse Rules Training." That training includes a slide on "Confirmed, Not Registered" abuse reports, which gives some perspective to Cole's case. An example is given that provides:

Analysis

- A staff member is grabbed from behind by a large male resident suffering from dementia and complications from changes in medication. The staff member reacts by putting an elbow into the person's stomach, resulting in a minor and temporary injury to the resident.
- =Physical injury
- =Confirmed, not registered if interviews reveal the action was reflexive, not intentional.

Another DIA training slide provides:

Founded or
Confirmed Not Registered
FOUNDED ABUSE

▼	▼
No disciplinary Actions Positive Interviews Reflexive/Frustration	Prior Discipline(s)* Negative Interviews Not reflexive Pattern
▼	
Incident is minor, isolated and unlikely to reoccur	
▼	▼
Confirmed Not Registered	**Founded**

*Disciplinary actions related to similar actions/incidents

Additionally, DHS rule 441—176.13 provides in part:

> **176.13(4)** *Assessments.* Reports classified as assessment shall not be included in the central registry but shall be maintained in the local office. . . .
>
> . . . .
>
> *b. Confirmed, not registered.* Reports of dependent adult abuse where physical abuse or denial of critical care committed by a caretaker is confirmed but is determined to be minor, isolated, and unlikely to reoccur shall be assessments. . . .

Cole timely filed an appeal of DIA's report. Cole subsequently entered into the Consent Order that reflects his evidentiary hearing was pending. It further states, "Informal settlements of controversies that may culminate in contested case proceedings are encouraged under Iowa law." The next line provides the

parties entered into "discussions aimed at informal resolution of this case," which culminated in the Consent Order.

Although these additional facts are relevant to our conclusions, they also form a basis, along with other evidence, for our agreement with the ALJ in finding Cole truthful during GRC's investigation and his account credible. Cole appealed the DIA's report. Cole's appeal was not an admission of guilt, but reflects his disagreement with DIA's conclusions. The State does not dispute the ALJ's findings that set forth Cole's explanation why he subsequently entered into the Consent Order. The findings provide in part, "Cole explained [to the GRC investigator on August 4,] that he agreed to accept a 'confirmed, not registered' disposition on the dependent adult abuse allegation upon the advice of his attorney because it would guarantee that he would not be placed on the DHS central abuse registry." "This certainty was important to him because it meant that he would not be statutorily prohibited from working at a care facility." Cole then described the January 27 incident with DW to the investigator consistent with his initial account that he had given to another investigator. Cole's description of the event and explanation for entering into the Consent Order remained consistent when he was interviewed yet again on August 7. Throughout this period, Cole was consistent in his account of the January 27 incident and why he subsequently entered into a Consent Order.

We do not find Cole's agreement to the Consent Order to be his admission of guilt that he intentionally "kicked" DW. We find his explanation credible that he entered into the agreement upon the advice of his attorney for an informal resolution with certainty to protect his ability to continue working in a care

facility. As the DIA training reflects, a confirmed, not registered report of dependent adult abuse is warranted where the action was not intentional, there are no disciplinary actions, the action was reflexive or from frustration, and the incident is minor, isolated and unlikely to reoccur. A "founded" report on the other hand is one where there has been prior disciplinary action, there are negative interviews, the action was not reflexive, and there is a pattern of this conduct. Based on this information, we are not at all persuaded that Cole's agreement to a confirmed, not registered report somehow translates to an admission that he intentionally "kicked" DW and thus, untruthful in the investigation. Rather, we find Cole was truthful and consistent in his account throughout the investigations.

In our review and during oral arguments, we spent considerable time addressing the definition of "physical abuse." The GRC investigation relied upon a definition that the ALJ noted, "the source of this definition is unknown on the record." The State was unable to identify the source during oral arguments and stated that GRC staff was required to follow Iowa Code and Federal regulations.

The DIA training slide on dependent adult abuse provides,

> What is Dependent Adult Abuse?
>
> - Any of the following as a result of the *willful misconduct* or *gross negligence* or *reckless acts* or *omissions* of a caretaker taking into account the totality of the circumstances:
> - Physical injury
> - Unreasonable Confinement
> - Unreasonable Punishment
> - Assault
> - Sexual Offense
> - Exploitation
> - Neglect
> - Sexual Exploitation

Another slide states "Willful Misconduct" "means an intentional act of unreasonable character committed with disregard for a known or obvious risk that is so great as to make it highly probable that harm will follow."

CONCLUSIONS OF LAW

We have carefully considered the State's arguments in our review of the ALJ's conclusions. The ALJ followed well-established case law and correctly examined the totality of circumstances to reach her determination the State did not establish just cause existed to support its termination of Cole. *See Hoffmann & State of Iowa (Dep't of Transp.)*, 1993 MA 21 at 23. The ALJ set forth a thorough and rational analysis of the factors in reaching her conclusions. We agree with the ALJ's conclusions as set out in the Appendix and adopt them as our own, with the following additional discussion:

The ALJ concluded Cole had violated DHS work rule D-1(22), which provides,

> Employees shall not mistreat, abuse, coerce, neglect or exploit employees, visitors or clients, whether verbally, physically, sexually or financially.

The ALJ based her conclusion on the definition of "physical abuse" provided in the investigative report:

> "Physical abuse" is defined as: An act that causes, or may have caused injury to an individual. Physical abuse includes but is not limited to:
> - Hitting, slapping, pushing, pinching, throwing objects directed at the individual or otherwise striking an individual;
> - Physical assault;
> - Corporal punishment (physical punishment for an individual's actions);
> - Use of excessive force (failure to use least restrictive interventions);

- Unauthorized use of restrictive interventions including restraint, seclusion, aversive conditioning, time out or punishment; or
- Incitement to act, which includes circumstances where caretakers instigate individuals to inflict harm on another individual(s).

No citation to Iowa Code or rules provided.

The source of the investigator's definition is unknown. As the State pointed out, there are different standards and definitions of abuse for dependent adults who reside in facilities in comparison to those who have their own caretakers. Iowa Code chapter 235E addresses "Dependent Adult Abuse in Facilities and Programs" and section 235E.1(5)(*a*) provides in relevant part:

> **235E.1 Definitions.**
> 5. *a. "Dependent adult abuse"* means:
> (1) Any of the following as a result of the willful misconduct or gross negligence or reckless acts or omissions of a caretaker, taking into account the totality of the circumstances:
> (a) A physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement, unreasonable punishment, or assault of a dependent adult which involves a breach of skill, care, and learning ordinarily exercised by a caretaker in similar circumstances. "Assault of a dependent adult" means the commission of any act which is generally intended to cause pain or injury to a dependent adult, or which is generally intended to result in physical contact which would be considered by a reasonable person to be insulting or offensive or any act which is intended to place another in fear of immediate physical contact which will be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act.
> . . . .

Iowa Code § 235E.1(5)(*a*).

The investigator's definition of "physical abuse" does not require that the act was willful misconduct, gross negligence, reckless, or an omission. Nor does it take into account the "totality of circumstances" as the Iowa Code section 235E.1 legal definition requires. It is a much lower threshold that includes the

failure to use the least restrictive intervention, which arguably "may" result in injury every time.

Based on the Iowa Code definition for dependent adults residing at facilities, Cole's actions do not constitute "physical abuse." If we believe Cole's account, and we do, then there is an absence of willful misconduct, gross negligence, recklessness, and omission on his part to constitute "physical abuse." *See* Iowa Code § 235E.1.

The ALJ determined Cole's actions were ones which may cause injury and constituted a failure to use the least restrictive intervention, which Cole had admitted he had not used in this instance. In accordance with the investigator's definition, the ALJ concluded Cole's actions constituted "physical abuse" in violation of DHS work rule D-1(22). We do not disagree with the ALJ's conclusion based on the investigator's definition of "physical abuse." However, based on the evidence, there is ambiguity in what is the relevant definition of "physical abuse," which should be taken into consideration.

One factor considered relevant to a just cause determination is whether the employee has been given forewarning or has knowledge of the employer's rules. *Id.* When there is ambiguity in what constitutes "physical abuse," notice of the expected conduct is lacking. The State failed to provide any evidence that Cole was aware that his failure to use the least restrictive intervention may constitute "physical abuse." As the ALJ's analysis provides, and the State confirmed in oral arguments, the investigator's source of the definition is not noted in the record. The State indicates that GRC must follow Iowa law and yet,

the investigator utilized a definition of "adult abuse" that is different from Iowa Code section 235E.1 and the DIA training.

In any event, based on the investigator's definition, we reach the same determination and conclusion as the ALJ because Cole failed to utilize proper training techniques. Thus, Cole violated DHS work rule D-1(22) when he admittedly failed to use the least restrictive method of restraint with DW that resulted in Cole's foot striking DW. Because the State failed to establish the source of the investigator's definition of "physical abuse" and this definition significantly differs from the legal definition, we conclude there was not sufficient notice to Cole that his failure to utilize the least restrictive form of restraint on January 27 constitutes "physical abuse" and a violation of DHS work rule D-1(22). This ambiguity in what definition of "physical abuse" is applicable and lack of notice are factors we considered in our review and in reaching our conclusion.

We also carefully considered Cole's agreement to a confirmed, not registered report in the context of the DIA training materials and the DHS rule. As our additional findings reflect, a "confirmed, not registered" report of abuse is quite different from a "founded" report. Cole's situation fits the description for a confirmed, not registered report. Cole had no other prior discipline; there were positive interviews about his interactions and demeanor with residents; and the January 27 incident was the result of his failure to use the least form of restrictive intervention and Cole's actions were not willful or intentional. We think Cole's actions on January 27 were minor, isolated, and unlikely to reoccur. We take this into account in reaching our final conclusion.

The ALJ set forth a thorough and rational analysis of all factors she considered in reaching her conclusions. We disagree with the State that the ALJ should have considered a 2005 incident. Not only was there a significant passage of time since this incident, but more importantly, the State did not rely on this incident in making its decision to terminate Cole. It was not cited as a basis in the State's decision in the letter of termination to Cole. Along with our discussion, we agree with the ALJ's consideration and weight given each factor to conclude that a three-day suspension is warranted.

Accordingly, we enter the following:

ORDER

The Department of Human Services shall reinstate Aaron Cole to his former position as a Resident Treatment Worker at the Glenwood Resource Center (if the position still exists, and if not, to a substantially equivalent position), with back pay and benefits, less interim earnings and any other deductions associated with a three-day suspension; restore his benefit accounts to reflect accumulations he would have received but for the discharge less any adjustments for the three-day suspension; make appropriate adjustments to his personnel records and take all other actions necessary to restore him to the position he would have been in had he instead been issued a three-day suspension on August 24, 2017.

The cost of reporting and of the agency-requested transcript in the amount of $573.50 are assessed against the State of Iowa, Department of Human Services, pursuant to Iowa Code section 20.6(6) and PERB rule 621—11.9. A

bill of costs will be issued to the State of Iowa in accordance with PERB subrule 11.9(3).

This decision constitutes final agency action only on the issue of whether the State established just cause for Cole's termination. The Board retains jurisdiction of this matter in order to address any remedy-related matters, which might hereafter arise and to specify the precise terms of the remedy. In order to prevent further delay in the resolution of this matter, in the event the parties fail to reach agreement and in the absence of a party filing a petition for judicial review, the Board will schedule a hearing within 45 days of the below date to receive evidence and arguments on the precise terms of the remedy. Agency action on the appropriate remedy will not be final until its specifics are approved or determined by the Board. The Board retains jurisdiction to enter whatever orders may be necessary or appropriate to address any remedy-related matters which may hereafter arise.

DATED at Des Moines, Iowa, this 3rd day of March, 2020.

PUBLIC EMPLOYMENT RELATIONS BOARD

Cheryl K. Arnold, Chairperson

Jamie K. Van Fossen, Board Member

Mary T. Gannon, Board Member

Original filed EDMS.

APPENDIX A

STATE OF IOWA
BEFORE THE PUBLIC EMPLOYMENT RELATIONS BOARD

AARON COLE, Appellant, and STATE OF IOWA (DEPARTMENT OF HUMAN SERVICES), Appellee.	)	CASE NO. 102113

PROPOSED DECISION AND ORDER

Appellant Aaron Cole filed this state employee disciplinary action appeal with the Public Employment Relations Board (PERB) on October 23, 2017, pursuant to Iowa Code subsection 8A.415(2)(*b*) and PERB subrule 621—11.2(2). He alleges the termination of his employment on August 24, 2017, from the Iowa Department of Human Services - Glenwood Resource Center (DHS-GRC) is not supported by just cause. The State contends Cole was terminated for just cause after an internal investigation concluded that he committed abuse against a GRC resident and failed to be truthful regarding the alleged abuse.

Pursuant to notice, a closed evidentiary hearing on the merits of the appeal was held before me on August 29, 2018, in Des Moines, Iowa. Cole was represented by Julie Dake Abel and Earlene Anderson. The State was represented by Alla Mintzer Zaprudsky and Henry Widen. Both parties submitted post-hearing briefs, which were received on October 12, 2018.

Based upon the entirety of the record, and having reviewed and considered the parties' arguments, I make the following findings of fact, conclusions of law, and order:

APPENDIX A

FINDINGS OF FACT

Appellant Cole was hired by GRC in May 2000 as a Resident Treatment Worker (RTW). GRC is a DHS-operated intermediate care facility for intellectually disabled individuals (ICF/ID) which provides care, support and treatment for individuals with a wide range of intellectual disabilities.[1]

RTWs provide 24-hour supervision to GRC residents. They also provide care related to the residents' health, safety, grooming and hygiene, social, dietary, and behavioral needs as outlined in the residents' individual behavior support plan (BSP). RTWs receive training on different aspects of their duties and responsibilities, including training on the implementation of BSPs, prevention and reporting of abuse, protection of residents' rights, dignity and respect, and accountability. RTWs are also trained on the Mandt system, which teaches caretakers appropriate techniques for interacting with residents and, when necessary, physically intervening or redirecting residents who exhibit behavioral issues. Cole has received training on the Mandt system about once a year since 2007. He has similarly received training on awareness, reporting, and prevention of abuse about once a year since 2007.

Cole's 17-year tenure as an RTW has been regarded as positive and satisfactory. His last performance evaluation, dated April 25, 2016, reveals he met all set goals and expectations.[2] Cole was considered a "team player" with a good

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[1] GRC is licensed as an ICF/ID by the Iowa Department of Inspections and Appeals (DIA). As a licensed facility, GRC is required to promptly report to DIA any incidents that could constitute "dependent adult abuse" within the meaning of Iowa Code subsection 235E.1(5)(*a*).

[2] Cole's annual performance evaluations prior to April 2016 are not part of the record.

attitude. Cole's evaluation also noted that he maintained a good relationship with all the residents in his assigned house and treated everyone with dignity and respect.

GRC's management and staff have regarded Cole's interactions with residents as positive, appropriate, and consistent with training. Cole has always been observed utilizing appropriate Mandt blocking and redirection techniques with residents. In the years they have worked with Cole, staff and management have not had cause for concern or a need to address Cole's interactions with residents. Family members of GRC residents have also never expressed any concern regarding Cole's care of residents while some have even commended Cole's genuine interest and eagerness to help the residents he supervises.

Some of Cole's supervisors have particularly taken notice of his consistently "calm" and "mild-mannered" demeanor, noting that Cole has never gotten "worked up" while supervising residents. He was willing to supervise any resident, including residents with escalated behavioral issues that other RTWs were sometimes unwilling to supervise. Even during escalated behavioral incidents when residents have put Cole "through the wringer," he never appeared fazed and handled the situation appropriately.

Other than the instant termination, Cole has no other disciplinary action in his personnel file. The record indicates he was disciplined in 2005 but that disciplinary action was subsequently overturned through arbitration. The termination of his employment at issue here was summarily imposed; it was not based on progression from prior performance deficiencies or discipline. During his 17-year employment with GRC, Cole was investigated once for alleged physical

abuse and once for neglect. The physical abuse allegation was determined to be unsubstantiated. The neglect allegation was substantiated but the record is devoid of any other information regarding the date or circumstances about the neglect incident. It is also unknown on this record whether that neglect finding was the basis of Cole's 2005 disciplinary action that was subsequently overturned.

For the last ten years of his employment at GRC, Cole was assigned to House 360, which houses adult males with intellectual and physical disabilities. He worked the 6:00 a.m. to 2:30 p.m. shift. The incident precipitating Cole's termination occurred on January 27, 2017, during his supervision of resident DW in House 360. Cole was alleged to have "kicked" DW, an allegation that led to an internal investigation into physical abuse. The investigation consisted of interviews with three individuals, witness reenactment videos of the incident, a survey of the area where the incident occurred, and a medical assessment of DW.

The events of January 27 are mostly undisputed but certain details regarding the physical contact between Cole and resident DW differ in several respects. In making findings between conflicting evidence, I have credited such evidence which is most reasonable and consistent with the record as a whole, giving consideration to established criteria for making credibility determinations, such as the witnesses' actual knowledge and ability to observe the event in question, corroboration or contradiction by other established facts, and plausibility when all other evidence is considered.

Resident DW is non-verbal with profound intellectual disabilities and multiple diagnoses including epilepsy, cervical spinal stenosis, and amblyopia. DW is able

to move and walk on his own but has an unsteady gait, which appears like a stagger or sway while ambulating. DW has a litany of known target behaviors, but those present on January 27 included certain compulsive behaviors (frequent clothing changes), aggression (pushing, biting, hitting), self-injurious behaviors (SIB) (picking sores, picking skin), holding his breath until he loses consciousness, and stripping his clothing. When DW engages in stripping, his BSP indicates that staff is to direct him to his bedroom or other private area. DW is to remain in his bedroom if he is not fully clothed and the RTW is to remind him every five minutes to put his clothes on while providing no other social interaction until he complies. If DW strips in a non-private area, staff is directed to place a privacy screen around him until he is redirected back to his bedroom.

DW requires one-on-one supervision. The assigned staff must remain in the same room with him while he is awake and be able to intervene within five seconds. The assigned staff must rotate supervision at least every four hours but can rotate every hour if DW is exhibiting increased compulsive-type behaviors. While some GRC staff did not want to be accountable for DW due to his increased target behaviors and outbursts, Cole was willing to and quite frequently assigned as DW's one-on-one staff. DW was perceived to do well with Cole as his assigned staff.

On January 27, Cole was assigned to supervise DW on two separate occasions. He first had accountability of DW for several hours starting at 6 a.m. DW exhibited several target behaviors, including stripping, picking at his cuticles until they bled, attempting to bite Cole several times when he tried to apply pressure to DW's cuticles, and throwing his hamper and other objects at Cole. DW eventually

calmed and ate breakfast. Another RTW took over supervision for a period of time until Cole again took over accountability of DW at 10:30 a.m.

Around 11:40 a.m., DW had removed his shirt and refused to put it back on or allow Cole to place a gait belt on him. He then held his breath until he passed out. Without a gait belt, Cole had nothing to grab ahold of to help ease DW's fall. DW fell by his dresser and hit his nose, causing a cut to the right side of it. Cole reported the incident to John Wade, a treatment program manager in House 360, and the incident was noted in DW's event log. Cole walked DW to the dining room to eat lunch, placing a privacy screen around him while he ate because he was still without a shirt. After lunch, Cole directed DW back to his room. DW still refused to put on a shirt as he walked around his room, pacing between his bed and dresser while throwing his clothes around. Cole continued to supervise DW.

GRC superintendent Gary Anders arrived at House 360 around 12:17 p.m. to conduct his weekly rounds. He walked through the various parts of the home while observing staff interactions with residents. As he walked down a hallway leading to the residents' bedrooms, Anders saw Cole and DW inside DW's bedroom. Cole was seated in an office-type chair with armrests and wheels about four to five feet inside the bedroom. The double doors to DW's bedroom were open, but the record is unclear whether DW's bedroom was located directly in front of Anders or to the side as Anders walked down the hallway.

Although house plans were reviewed, site visits conducted, and photographs taken during the investigation, those items are not part of the record. Instead, the distance between Anders, Cole, and DW at the time of the incident are witness-

provided approximations. Those approximations indicate that Anders was about 15 to 20 feet away from the bedroom door when he observed Cole and DW. Cole was still seated in an office-type chair about 4 to 5 feet inside the bedroom, and based on those approximations, Cole would have been about 20 to 25 feet away from Anders with his back to the door. DW was standing by his bed that was about 8 to 10 feet from the bedroom door.

Although certain details and characterization regarding the January 27 incident are disputed, the record reveals the following occurred. As Anders spotted Cole and DW in the resident's bedroom, DW began to walk toward the door where Cole was seated, ambulating in his typical stagger or sway-like manner. DW was still without a shirt. To block DW's exit, Cole pushed his chair back with his left foot, and then raised and extended his right foot as DW walked toward the door. Cole's foot made physical contact with DW's leg somewhere between his knee and hip crease. Upon contact, DW stopped and took a step or two back before turning around.

One disputed detail about the incident is whether Cole remained seated in the chair at the time he raised his foot. Anders asserts that Cole first lifted himself into a semi-standing position before extending his foot while Cole maintains that he remained seated the whole time. This is not a dispute that needs to be resolved. Regardless if Cole was seated or semi-seated at the time his foot made contact with DW, the material issue underlying the abuse allegation is the actual contact that resulted when Cole extended his foot.

APPENDIX A

A disputed fact that is material to the instant appeal is whether Cole purposefully and forcefully "kicked" DW, as Anders described the incident. Cole acknowledged his foot made contact with DW but disputes Anders' characterization of it as a forceful or purposeful kick. Resolving this dispute between the only two witnesses to the event requires looking at other established evidence in the record.

The record demonstrates that Cole's extended foot was flat, not pointed, at the time of contact. Furthermore, whatever amount of force was behind the contact, it was not strong enough to cause DW to fall or stumble even though he has a generally unsteady gait. It also did not cause DW to express any other visible reaction to the contact. A full medical assessment that was completed about half an hour after the incident did not reveal any visible marks or bruises on DW's lower body where the contact occurred. These undisputed facts corroborate a finding that the physical contact was not any more forceful than can be plausibly attributed to the fact that Cole raised his foot at the same time as DW approached from the opposite direction, resulting in force that only blocked DW's forward progress but did not make him stumble, fall, or otherwise react.

The record as a whole also does not establish that Cole's intent in extending his foot was to "kick" DW. First, Cole's purported reason for raising his foot in order to keep DW inside his room is consistent with other established facts. RTWs are directed to keep DW in his bedroom or other private area when he is not fully clothed, as was the case at the time. Cole raised his foot only as DW began to walk toward the bedroom door. Additionally, distance approximations provided by this record establish that DW was only about 4 to 5 feet away from Cole when he started walking

in Cole's direction. The timing of Cole extending his foot, coupled with the short distance between him and DW, support a finding that his intent was only to block DW's exit from the bedroom using his foot, not to intentionally "kick" DW. This finding is further supported by a lack of any evidence about Cole's interactions with residents, including DW, which may suggest he would intentionally "kick" a resident. Wade interacted with Cole shortly before this incident and Wade did not report anything concerning about Cole's demeanor with DW that may explain why Cole would make the decision to intentionally kick the resident. To the contrary, the record indisputably reveals that Cole has maintained a calm and appropriate demeanor when supervising residents with very challenging behavioral issues. The record as a whole supports a finding that Cole's action of raising and extending his foot was not done with the intent to "kick" or otherwise strike DW but to merely block him from leaving his bedroom because he was not fully dressed.

Upon witnessing the physical contact between Cole and DW, Anders did not discuss the incident with Cole but immediately directed him to report to the supervisor's office. Anders called for Wade to find another staff to take over supervision. Once Cole signed over accountability of DW and left, Anders told Wade that he witnessed Cole "kick [DW] in the groin" and that he needed to be suspended for abuse. Anders left House 360 around 12:25p.m., having been in the home for about eight minutes total.

Cole was placed on paid administrative leave the same day. GRC also promptly notified DIA pursuant to Iowa Code chapter 235E, Dependent Adult Abuse

in Facilities and Programs, about potential dependent adult abuse. DIA and GRC conducted independent investigations into the January 27 incident.

GRC began an investigation into "physical abuse" shortly after the incident on January 27 and concluded its investigation by February 8, 2017. GRC's investigation relied upon the following definition of "physical abuse," although the source of this definition is unknown on the record before me:

> "Physical abuse" is defined as: An act that causes, or may have caused injury to an individual. Physical abuse includes but is not limited to:
> - Hitting, slapping, pushing, pinching, throwing objects directed at the individual or otherwise striking an individual;
> - Physical assault;
> - Corporal punishment (physical punishment for an individual's actions);
> - Use of excessive force (failure to use least restrictive interventions);
> - Unauthorized use of restrictive interventions including restraint, seclusion, aversive conditioning, time out or punishment; or
> - Incitement to act, which includes circumstances where caretakers instigate individuals to inflict harm on another individual(s).

A full head to toe medical assessment of DW was completed on the date of the incident around 1:00 p.m. DW did not indicate any pain. His right and left lower extremities were noted to have full range of motion. No new marks or scratches were discovered that had not previously been documented. The assigned GRC investigator visited DW's bedroom around 12:50 p.m. and then again at 1:30 p.m. to take photographs of DW, the inside of his bedroom, and DW's bedroom as seen from the hallway. He also reviewed House 360 floor plans to identify where the incident took place and the proximity of the individuals to the incident at the time it occurred. The photographs, house plans, and any other diagrams collected and reviewed as part of the investigation are not part of this record.

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Anders, Wade, and Cole were interviewed as part of GRC's investigation. DW was not interviewed about the incident because he is nonverbal. Cole was interviewed on January 27 and January 31, provided two written statements dated January 27 and January 31, and did a reenactment video of the incident on January 31. Anders was interviewed on January 27, signed a written statement sometime after January 30, and did a reenactment video on February 2.[3] Wade was interviewed on January 30.

GRC's investigation reveals that Cole acknowledged his foot made contact with DW and that the actions he took to block DW are inconsistent with the Mandt techniques and training. Cole recognized it was a mistake to extend his foot to block DW and that he should have instead stood up from the chair when DW headed toward the door. He admitted his deviation from training on the day of the incident during his first interview, in his written statement, and during his second interview.

GRC concluded its investigation on February 8 with a substantiated abuse finding, stating in part:

> The preponderance of evidence suggests Cole was attempting to restrict [DW] to his room and in doing so used excessive force and an unauthorized method to prevent [DW] from leaving his room. Based on the information collected, it is also believed that Cole purposefully kicked [DW] by extending his right leg with force and making contact with [DW]. It does not appear [DW] sustained any injury as a result of the interactions with Cole. Physical abuse is substantiated.

On February 8, GRC's Incident Review Committee reviewed the investigative findings and agreed the allegation of physical abuse was substantiated. GRC did not

[3] Wade wrote Anders' written statement sometime on or after January 30 based on the description of the incident that Anders provided to Wade on January 27. Anders reviewed the statement for accuracy prior to signing it.

make any decision regarding the appropriate disciplinary action to impose as GRC generally waits for DIA's final determination on the dependent adult abuse report before imposing discipline.

DIA conducted its separate investigation between January 30 and February 2, 2017. Based on GRC's report of potential abuse, DIA investigated the January 27 incident as an "assault," a category of dependent adult abuse defined by Iowa Code chapter 235E. In evaluating a report of dependent adult abuse, DIA could determine the allegation was "founded," "unfounded," or "confirmed, not registered." Only certain abuse categories are eligible for a "confirmed, not registered" disposition, which are physical injury, unreasonable punishment, unreasonable confinement, assault, and neglect. The "confirmed, not registered" disposition is statutorily available pursuant to chapter 235E for abuse reports which DIA determines are "minor, isolated, and unlikely to reoccur" and thus do not warrant the caretaker being placed on the DHS central abuse registry.

The record reveals that GRC relied upon DIA's final resolution on the dependent adult abuse report to determine the appropriate level of discipline to impose in this case. As such, DIA's investigation pursuant to Iowa Code chapter 235E has some relevance to the instant Iowa Code section 8A.415 appeal. The relevance is limited, however, by the fact that GRC did not have the contents of DIA's investigation prior to deciding to terminate Cole's employment and that DIA's investigation was based on the Iowa Code chapter 235E statutory definition of "dependent adult abuse," which is different than GRC's definition of "physical abuse" for which Cole was terminated.

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DIA's investigation included interviews with Cole, Anders, Wade, one resident treatment supervisor, three RTWs who work with Cole in House 360, and two members of DW's family. The DIA investigator also conducted two site visits to observe DW's interactions with staff. DIA's interview with Cole reveals that Cole's description of the incident to DIA is consistent with the description he provided to GRC. During its on-site visits, DIA observed DW exhibiting the same type of target behaviors he exhibited on January 27 while under Cole's supervision, including self-injurious behaviors, stripping, and attempting to push past staff to exit his bedroom when not fully clothed. When he attempted to leave the bedroom without being fully clothed, the assigned staff physically blocked DW's exit from the bedroom.

On March 6, 2017, DIA sent Cole a "Notice of Investigative Findings" and a "Comprehensive Abuse Memo" informing him the allegation of dependent adult abuse based on "assault" was determined to be "founded." The enclosed "comprehensive abuse memo" contained the interviews, on-site observations, and other evidence gathered during DIA's investigation. Unless timely appealed, a "founded" disposition for dependent adult abuse would result in the caretaker's inclusion on the DHS central abuse registry and statutorily prohibit the employee from continuing employment at GRC.

On March 6, DIA also informed GRC of its determination by mailing a "notice of investigative findings." The notice sent to GRC did not contain any witness interviews or other evidence collected. The notice only informed GRC that the allegation of dependent adult abuse based on "assault" was determined to be "founded." The notice also contained the following summary of findings:

> It is alleged on 1/27/17 at approximately 12:20 p.m. RTW Aaron Cole kicked client [DW] near the right side of his abdominal/groin area. Based on witness interview, there is a preponderance of evidence to support the allegation of abuse.

The "witness interview" referenced in the summary refers to DIA's interview with Anders, the only named "witness" who observed the incident.[4]

Cole timely appealed DIA's determination and sought review of the findings in a contested case hearing. Prior to the scheduled hearing, however, Cole and DIA agreed to resolve the abuse allegation by consent order without a contested case hearing. The order was entered on June 19, 2017, with the following agreement, stating in part:

> 8. For the purposes of this **Consent Order**, the parties agree to the following:
> (a) That the Appellant [Cole] agrees to waive his right to a contested case appeal hearing on this matter.
> (b) The Respondent [DIA] and Appellant [Cole] agree that Report Number 65608-M (DHS Registry Number 104865) [Notice of Investigative Findings and Comprehensive Abuse Memo] shall be amended to **Confirmed, Not Registered**.
> (c) The Appellant's record shall be maintained by DHS as an assessment only for a five year period.
> 9. In consideration of the agreements set forth herein, the Appellant expressly waives any and all rights to a contested case hearing before a State Administrative Law Judge on all issues pending on appeal before DIA arising out of the aforementioned Report.
> 10. The items agreed upon in this **Consent Order** comprise the sum total of the matters agreed upon and incorporated by reference and no other matters are considered as part of this agreement.

GRC received a copy of the consent order from DIA sometime after June 19. Upon receipt, GRC determined to reopen its internal investigation because it

[4] Cole is referred to as "perpetrator" in DIA's comprehensive abuse memo.

considered Cole's agreement to the consent order to be an admission of abuse, which was different from his assertions during GRC's investigation that no abuse occurred.

GRC conducted an interview with Cole on August 4, 2017. Cole was first reminded and asked to sign an acknowledgement form confirming he understood the DHS work rule requiring him to cooperate and be honest in his responses during the investigation. After reading paragraph 8(b) of DIA's consent order, the investigator asked a series of questions regarding Cole's understanding of the consent order and what "abuse" he "confirmed" by agreeing to it. Cole explained that he agreed to accept a "confirmed, not registered" disposition on the dependent adult abuse allegation upon the advice of his attorney because it would guarantee that he would not be placed on the DHS central abuse registry. This certainty was important to him because it meant that he would not be statutorily prohibited from working at a care facility. The investigator, who was not the same investigator from the initial investigation, asked Cole to again describe the January 27 incident. His description was consistent with his initial description of the incident. Cole further stated the description is the truth about what occurred on January 27.

During the August 4 interview, the investigator made several statements about her take on the meaning of the consent order, such as that Cole's agreement means the abuse is "substantiated or confirmed." She also stated that Cole's statements to her did not match what he signed because his signature on the consent order meant that he agreed with DIA's initial finding that he "kicked" DW. Cole again reiterated that his reason for agreeing to the consent order was to guarantee he would not be placed on the abuse registry. Cole was interviewed again

on August 7 with the same line of questioning. Cole provided the same answer as on August 4, maintaining that he had been truthful about what occurred on January 27 but agreed to the consent order to avoid any risk of being placed on the abuse registry.

Cole's *Loudermill* interview was conducted on August 24. He did not have any additional information to share with GRC and the interview concluded. He was terminated the same day, August 24. His termination letter stated, in pertinent part:

> This letter is to serve as notice of termination from the Glenwood Resource Center (GRC) effective today. This action is being taken as a result of our investigation which determined violations of the DHS work rules and the GRC Incident Management Policy.
>
> The investigation revealed that physical abuse was perpetrated by you on a GRC client and you failed to be truthful and forthcoming when interviewed regarding these matters.
>
> You actions are in violation of the following DHS work rules, which state:
>
> **Section D-1 General Standards of Conduct and Work Rules**
>
> ***
>
> 10. Employees shall not make false, misleading or malicious statements concerning themselves, other employees, clients, and supervisors, or falsify forms or work documents, or intentionally enter false information into automated systems, or intentionally give false or misleading information, or omit information significant to the Department.
>
> 22. Employees shall not mistreat, abuse, coerce, neglect or exploit employees, visitors or clients, whether verbally, physically, sexually or financially.

The GRC Incident Management Policy referenced in the termination letter is not part of this record.

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GRC determined to terminate Cole's employment because it concluded that GRC's investigation as well as DIA's initial abuse determination and final consent order "all agreed that there was an incident of abuse that was confirmed." GRC also concluded that Cole maintained "an insistence that the incident had not occurred, and he would not take responsibility for the incident as it occurred." GRC determined this was strong indication Cole would be unreliable in reporting and preventing any future abuse of GRC residents.

GRC indicated it has made "similar decisions" in other situations but failed to provide any examples of similar disciplinary actions. The record is also devoid of any indication that GRC considered the treatment of other similarly situated employees with "substantiated" physical abuse. Cole presented the prior discipline of another RTW who had a substantiated neglect finding after it was determined she had fallen asleep while supervising a one-on-one resident. The final DIA determination on the neglect allegation, a category of abuse under Iowa Code chapter 235E, was a "confirmed, not registered" disposition. Although it is unclear what level of discipline GRC imposed on this RTW, she remained employed at GRC following DIA's "confirmed, not registered" abuse disposition.

Cole appealed his termination to DAS on August 26, 2017, alleging the termination is not supported by just cause. DAS issued its third-step response on September 26, and denied the grievance. DAS concluded the DIA consent order is an admission abuse occurred because Cole agreed to a "confirmed" abuse finding as part of the settlement. As such, DAS found that the GRC investigation, the DIA investigation and the consent order all indicate that Cole "physically abuse[d] DW

when he kicked DW to prevent him from exiting his bedroom." DAS further concluded that termination is the appropriate penalty because Cole committed an "abusive act towards DW," a resident who was entrusted to his care. Cole appealed DAS's third-step response to PERB on October 23, 2017.

CONCLUSIONS OF LAW

Cole filed the instant state employee disciplinary action appeal pursuant to Iowa Code section 8A.415(2), which states:

> 2. *Discipline Resolution*
>
> a. A merit system employee . . . who is discharged, suspended, demoted, or otherwise receives a reduction in pay, except during the employee' s probationary period, may bypass steps one and two of the grievance procedure and appeal the disciplinary action to the director within seven calendar days following the effective date of the action. The director shall respond within thirty calendar days following receipt of the appeal.
>
> b. If not satisfied, the employee may, within thirty calendar days following the director's response, file an appeal with the public employment relations board. . . . If the public employment relations board finds that the action taken by the appointing authority was for political, religious, racial, national origin, sex, age, or other reasons not constituting just cause, the employee may be reinstated without loss of pay or benefits for the elapsed period, or the public employment relations board may provide other appropriate remedies.

The following DAS rules set forth specific discipline measures and procedures for disciplining employees.

> **11—60.2(8A) Disciplinary actions.** Except as otherwise provided, in addition to less severe progressive discipline measures, any employee is subject to any of the following disciplinary actions when the action is based on a standard of just cause: suspension, reduction of pay within the same pay grade, disciplinary demotion, or discharge. . . . Disciplinary action shall be based on any of the following reasons: inefficiency, insubordination, less than competent job performance, refusal of a reassignment, failure to perform assigned duties, inadequacy in the performance of assigned duties, dishonesty, improper use of leave, unrehabilitated substance abuse, negligence,

> conduct which adversely affects the employee's job performance or the agency of employment, conviction of a crime involving moral turpitude, conduct unbecoming a public employee, misconduct, or any other just cause.
>
> . . .
>
> **60.2(4)** Discharge. An appointing authority may discharge an employee. Prior to the employee's being discharged, the appointing authority shall inform the employee during a face-to-face meeting of the impending discharge and the reasons for the discharge, and at that time the employee shall have the opportunity to respond. A written statement of the reasons for the discharge shall be sent to the employee within 24 hours after the effective date of the discharge, and a copy shall be sent to the director by the appointing authority at the same time.

The State bears the burden of establishing that just cause supports the discipline imposed. *E.g., Phillips and State of Iowa (Dep't of Human Res.)*, 12-MA-05 at App. 11. The term "just cause" as employed in subsection 8A.415(2) and administrative rule 11—60.2 is not defined by statute or rule. *Stockbridge and State of Iowa (Dep't of Corr.)*, 06-MA-06 at 21 (internal citations omitted). Whether an employer has just cause to discipline an employee is made on a case-by-case basis. *Id.* at 20.

When determining the existence of just cause, PERB examines the totality of the circumstances. *Cooper and State of Iowa (Dep't of Human Rights)*, 97-MA-12 at 29. As previously stated by the Board,

> . . . a [§ 8A.415(2)] just cause determination requires an analysis of all the relevant circumstances concerning the conduct which precipitated the disciplinary action, and need not depend upon a mechanical, inflexible application of fixed "elements" which may or may not have any real applicability to the case under consideration.

Hunsaker and State of Iowa (Dep't of Emp't Servs.), 90-MA-13 at 40. The Board has further instructed that an analysis of the following factors may be relevant:

> While there is no fixed test to be applied, examples of some of the types of factors which may be relevant to a just cause determination, depending on the circumstances, include, but are not limited to: whether the employee has been given forewarning or has knowledge of the employer's rules and expected conduct; whether a sufficient and fair investigation was conducted by the employer; whether reasons for the discipline were adequately communicated to the employee; whether sufficient evidence or proof of the employee's guilt of the offense is established; whether progressive discipline was followed, or not applicable under the circumstances; whether the punishment imposed is proportionate to the offense; whether the employee's employment record, including years of service, performance, and disciplinary record, have been given due consideration; and whether there are other mitigating circumstances which would justify a lesser penalty.

Hoffmann and State of Iowa (Dep't of Transp.), 93-MA-21 at 23. PERB also considers how other similarly situated employees have been treated. *E.g. Kuhn and State of Iowa (Comm'n of Veterans Affairs),* 04-MA-04 at 42.

The presence or absence of just cause rests on the reasons stated in the disciplinary letter provided to the employee. *Eaves and State of Iowa (Dep't of Corr.)*, 03-MA-04 at 14. To establish just cause, the State must demonstrate the employee is guilty of violating the work rule, policy, or agreement cited in the disciplinary letter. *Gleiser and State of Iowa (Dep't of Transp.)*, 09-MA-01 at 17-18, 21. Cole's notice of termination indicates he was terminated for perpetrating physical abuse against a resident and for not being truthful and forthcoming during GRC's investigation about the alleged abuse, in violation of DHS work rules section D-1, paragraphs 10 and 22. Therefore, the initial issue to be addressed is whether the State has established sufficient evidence or proof that Cole violated the cited work rules.

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The State first asserts that Cole's actions on January 27 constituted "physical abuse" against resident DW and that his actions are thus in violation of DHS work rule D-1(22), which prohibits abuse against residents. GRC defines "physical abuse" as "an act that causes, or may have caused injury to an individual." The definition also includes a non-exhaustive list of "acts" that constitute physical abuse such as striking an individual, using excessive force, or using unauthorized restrictive interventions.

GRC's investigation concluded that Cole "purposefully kicked [DW] by extending his right leg with force and making contact with [DW]." Although Cole disagrees with this conclusion, he does acknowledge his foot made physical contact with DW. RTWs are allowed to make physical contact with residents when necessary, but using a foot to block a resident's exit from a room is not an appropriate or approved intervention technique. Cole recognized that using his foot to block DW was inconsistent with the Mandt techniques and training. In this instance, Cole's physical contact with DW did not leave any visible marks and DW, as a nonverbal individual, was unable to express whether he suffered any injury.

GRC's definition of "physical abuse" encompasses both acts that in fact caused an injury and acts that may have caused an injury. Even though the physical contact in this instance was not strong enough to leave a visible mark or cause DW to fall, this is the type of physical contact that may cause an injury. Thus, the physical contact that resulted from Cole raising and extending his foot is sufficient to constitute "physical abuse" under GRC's definition.

Cole contends he did not intend to "kick" DW when he raised his foot. For the purpose of determining whether Cole's actions constitute "physical abuse" as defined by GRC, demonstrating intent is not required. The definition only examines the caretaker's acts that caused or may have caused an injury, not his intent or lack of intent to injure. Thus, while Cole's lack of intent to "kick" or otherwise injure DW may be relevant to other considerations of just cause, it is not relevant to determining whether his actions fall within the definition of "physical abuse."

GRC's investigation also concluded that Cole used excessive force in his attempt to prevent DW's exit from the bedroom, which is a specific "act" listed under the "physical abuse" definition. As indicated by the parenthetical language within the physical abuse definition, excessive force is the "failure to use least restrictive interventions." GRC does not thoroughly explain how Cole's actions constitute excessive force, but the record presented demonstrates the proper intervention method in this instance required Cole to rise from his chair and stand in front of DW as he tried to exit the bedroom. Had Cole used this proper intervention technique, physical contact with the resident may not have occurred. In this instance, Cole's failure to use the proper intervention method resulted in more force than was required to block DW and, as such, his actions constitute excessive force.

GRC's investigation and witness testimony also seem to suggest Cole was unauthorized in his attempt to restrict DW to his bedroom because the BSP allows the resident free movement through the home while accompanied by staff. Under the record presented, I disagree with GRC's conclusion. While the BSP generally gives DW free movement through the home, the BSP also instructs staff to redirect

DW to his bedroom or other private area when he is not fully clothed. DW was without a shirt at the time Cole attempted to stop him from leaving the bedroom. During its on-site visits while investigating the January 27 incident, DIA also observed other staff restricting DW to his bedroom when he was not fully clothed. Therefore, under the record presented here, Cole was authorized to restrict DW to his bedroom because the resident was not fully dressed at the time of the incident.

For the reasons discussed, I conclude the State has presented sufficient proof that Cole's act of extending his foot and making physical contact with DW on January 27 falls within the definition of "physical abuse," and thus constitutes a violation of DHS work rule D-1(22) that prohibits abuse against residents.

The second violation contained in the termination letter is that Cole violated DHS work rule D-1(10), which prohibits employees from making false or misleading statements, or intentionally giving false or misleading information. GRC's basis for this conclusion is Cole's agreement to a "confirmed, not registered" abuse finding with DIA while asserting to GRC that no abuse occurred. GRC contends that Cole's signature on the consent order is an "admission" that he committed abuse.

In reaching its conclusion, GRC appears to have concluded the consent order in which Cole agreed to a "confirmed, not registered" disposition demonstrates his statements to GRC during the investigation were false. GRC's conclusion is premised on several faulty assumptions. First, its conclusion ignores the fact that the consent order itself does not contain any factual admissions. Next, although the initial notice of investigative findings and the comprehensive abuse memo are referenced, the consent order does not incorporate DIA's investigative findings other than to express

the parties' agreement to amend DIA's initial disposition from a "founded" to a "confirmed, not registered" disposition.[5] Finally, and most importantly, GRC's conclusion entirely disregards the context under which the consent order was signed. The consent order is a legal settlement that DIA and Cole agreed to in exchange for Cole waiving his right to a contested case hearing on the entirety of the findings. Legal settlements are frequently used to save parties time, money, and avoid the risk of litigating contested issues. As Cole informed GRC during his follow-up interviews, he accepted this settlement in order to guarantee a certain legal result regarding the DHS abuse registry.

Cole described the January 27 incident the same way to GRC and DIA, admitting he raised his foot and it made contact with DW, and that such act was not consistent with his training for blocking a resident. GRC has not provided any evidence that Cole made false or misleading statements about the events of January 27 during the GRC investigation. Thus, in the absence of any actual statements or information shown to be untruthful or misleading, I conclude GRC has not provided sufficient proof that Cole was untruthful or misleading during the GRC investigation in violation of DHS work rule D-1(10).

Having concluded that Cole's actions on January 27 violated DHS work rule D-1(22) regarding abuse, the next inquiry in this 8A.415(2) appeal is determining whether the violation shown constitutes just cause for termination. *Stockbridge,* 06-MA-06 at 27. Such inquiry involves examining whether progressive discipline

[5] Notably, DIA's definition of "dependent adult abuse" is different from GRC's definition of "physical abuse." Thus, it is unclear whether a determination of abuse under Iowa Code chapter 235E would constitute abuse under GRC's definition, or vice versa.

was applicable; whether the discipline imposed by the employer is proportionate to the proven misconduct; and whether the employer has imposed the same discipline or penalty upon other similarly-situated employees. *Id.* The length and history of the employee's job performance is also a relevant consideration. *Id.*

GRC argues that Cole's abusive conduct on January 27 and his subsequent refusal to take responsibility for the incident is so egregious that termination is warranted. Cole's role as an RTW is to care for residents, which includes protecting them against abuse. GRC maintains Cole's inability to recognize his conduct as abusive indicates his behavior cannot be corrected and that he would be an unreliable reporter of abuse if he were to remain employed. As such, GRC asserts, the principles of progressive discipline are inapplicable in this situation and summary termination is warranted given the seriousness of the misconduct.

Progressive discipline is a system where measures of increasing severity are applied to repeated offenses until the behavior is corrected or it becomes clear that it cannot be corrected. *E.g., Kelley and State of Iowa (Dep't of Corr.)*, 19 ALJ 102154 at 20 (internal citations omitted). Progressive discipline is used to encourage employees to take corrective responsibility to follow work rules and employment obligations. *Id.* Progressive discipline addresses an employee's behavior over time through escalating penalties. The purpose is to correct the unacceptable behavior of an employee and to convey the seriousness of the behavior while affording the employee an opportunity to improve. *Id.* However, progressive discipline may be inapplicable when the conduct underlying the discipline was a serious offense. *Phillips*, 12-MA-05 at App. 16-17.

Under the totality of the record presented before me, the State has not established that Cole committed the type of misconduct that renders progressive discipline entirely inapplicable or that his behavior cannot be corrected by imposing a penalty less severe than termination. The record does not indicate that GRC considered Cole's 17-year history of interactions with residents prior to determining termination was the appropriate penalty. Cole's lengthy tenure with GRC reveals a positive work record with no other incidents of physical abuse or any cause for concern that he may be abusive toward residents. Cole's superiors and co-workers praise Cole's consistently mild-mannered demeanor and appropriate handling of even the most challenging residents.

Furthermore, the record contains several relevant considerations about the January 27 incident that show summary discharge is disproportionate to the proven violation. Although GRC concluded Cole intentionally kicked DW, a preponderance of credible evidence received demonstrates otherwise. Cole made a quick decision, which was inconsistent with his training, to block DW using his foot. Cole's decision was certainly poor judgment and the fact that he made inappropriate physical contact with a resident warrants discipline. However, a single deviation from using an appropriate blocking technique that resulted in unintentional contact with a resident does not justify entirely forgoing progressive discipline.

I disagree with GRC's claim that Cole did not take responsibility for the incident. Under the record presented, Cole's unwillingness to label his January 27 acts as "abusive" is not equivalent to a refusal to take responsibility for his actions. Cole admitted the very same day that his actions were inconsistent with his training

and he should have blocked DW in a different manner. Cole's refusal to label his actions as "abusive" can be attributed to his mistaken belief that intent is an element of "physical abuse" under GRC's definition. The record establishes Cole admitted his foot made contact with DW, acknowledged that he exercised poor judgment in failing to follow an appropriate blocking technique, and recognized that he should handle the situation differently if it were to present itself again. These acknowledgements and recognitions that Cole made the same day of the incident demonstrate his misconduct can be corrected.

PERB has recognized instances when the employer is justified in skipping some disciplinary steps ordinarily imposed. *Barnard and State of Iowa (Dep't of Human Servs.)*, 17 ALJ 100758 at 21. Perpetrating abuse within the meaning of DHS work rule D-1(22) is a serious work rule violation and GRC is justified in skipping some steps of progression to communicate to Cole the seriousness of his actions on January 27. However, determining the appropriate penalty requires balancing any mitigating circumstances against the decision to terminate an employee. *Stockbridge*, 06-MA-06 at 27.

GRC has not demonstrated that every violation of work rule D-1(22) warrants summary termination regardless of the employee's work history or the mitigating factors that may be present. GRC has failed to present any prior incidents in which it summarily terminated employees for perpetrating "physical abuse." Notably, GRC has failed to demonstrate it considered any other similar actions that resulted in discipline before concluding termination was the appropriate level of discipline in this case. The only discipline known on this record that resulted

from a violation of work rule D-1(22) and a "confirmed, not registered" DIA abuse disposition was for the RTW who perpetrated "neglect." The RTW was not terminated but suspended for a period of time unknown on this record.

GRC asserts this other instance of discipline is not comparable to Cole's violation because that RTW was disciplined for "neglect" while Cole was found to have perpetrated "physical abuse." I am unpersuaded by the employer's position. Both neglect and physical abuse are categories of abuse against a dependent adult pursuant to Iowa Code chapter 235E. DHS work rule D-1(22) encompasses both "abuse" and "neglect" and both could result in injury to a resident. Thus, this other situation is relevant when determining how other employees who have violated D-1(22) were disciplined.

Termination is the ultimate disciplinary sanction. On the record presented here, the termination of Cole's employment is not consistent with progressive discipline and it is not proportionate to the proven misconduct. This is particularly true when the record reveals that, at least on one other occasion, another RTW received a lesser form of discipline for violating the same work rule and who also had a "confirmed, not registered" abuse disposition with DIA.

Having considered the entirety of the record and the arguments raised by the parties, I conclude Cole's violation of DHS work rule D-1(22) warrants discipline. However, one isolated incident of failing to use an approved blocking technique that resulted in unintended physical contact with a resident does not render progressive discipline entirely inapplicable. Cole's positive work history particularly in supervising residents, lack of intent to cause injury, lack of prior discipline or

concerns regarding similar deviations from proper intervention techniques, immediate acknowledgement and recognition that the situation should have been handled in a different manner, demonstrate that termination is disproportionate to the rule violation shown. Under the totality of the circumstances presented by the record here, just cause does not support summary discharge. The seriousness of the rule violation does justify skipping steps of progression and imposing a three-day suspension for a one-time violation of DHS work rule D-1(22) when Cole failed to utilize an appropriate blocking technique consistent with his training.

Consequently, I propose the following:

ORDER

The State of Iowa, Department of Human Services, shall reinstate Aaron Cole to his former position as a Resident Treatment Worker at the Glenwood Resource Center (if the position still exists, and if not, to a substantially equivalent position), with back pay and benefits, less interim earnings and any other deductions associated with a three-day suspension; restore his benefit accounts to reflect accumulations he would have received but for the discharge and less any adjustments for the three-day suspension; make appropriate adjustments to his personnel records and take all other actions necessary to restore him to the position he would have been in had he instead been issued a three-day suspension on August 24, 2017.

The cost of reporting and of the agency-requested transcript in the amount of $573.50 are assessed against the State of Iowa, Department of Human Services,

pursuant to Iowa Code subsection 20.6(6) and PERB rule 621—11.9. A bill of costs will be issued to the State of Iowa in accordance with PERB subrule 621—11.9(3).

This proposed decision and order will become PERB's final agency action on the merits of Cole's appeal pursuant to PERB subrule 621—11.7(2) unless, within 20 days of the date below, a party files a petition for review with the Public Employment Relations Board or the Board determines to review the proposed decision on its own motion.

The ALJ retains jurisdiction of this matter in order to address any remedy-related matters which might arise and to specify the precise terms of the remedy. In order to prevent further delay in the resolution of this matter, a hearing to receive evidence and arguments on the precise terms of the remedy, should the parties fail to reach agreement, will be scheduled and held within 45 days of the date this proposed decision becomes PERB's final action on the merits of Cole's appeal.

DATED at Des Moines, Iowa this 27th day of June, 2019.

/s/ Jasmina Sarajlija
Administrative Law Judge

Electronically filed.
Parties served via eFlex.