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PERB
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STATE OF IOWA
BEFORE THE PUBLIC EMPLOYMENT RELATIONS BOARD

SHERI ERGLE, Appellant,	)	
and	)	CASE NO. 102255
STATE OF IOWA (IOWA VETERANS HOME), Appellee.	)	PROPOSED DECISION AND ORDER

Appellant, Sheri Ergle, filed a state employee disciplinary action appeal with the Public Employment Relations Board ("PERB") pursuant to Iowa Code section 8A.415(2)(*b*) and PERB rule 621—11.2. Ergle appeals the third-step response of the Iowa Department of Administrative Services (DAS) finding just cause existed to issue her a three-day suspension.

Ergle worked as a resident treatment worker (RTW) for the State of Iowa, Iowa Veterans Home (IVH) in Marshalltown, Iowa. On September 6, 2018, IVH issued Ergle a five-day suspension for an incident that occurred during her care of Resident L. On Ergle's third-step grievance appeal to DAS, the DAS designee concluded a five-day suspension was not supported by just cause, but a three-day suspension was appropriate for the violation. Ergle contends the State did not have just cause to issue any discipline. The State asserts Ergle's three-day suspension was supported by just cause.

A closed, evidentiary hearing was held on November 19, 2019. The hearing reconvened on December 10, 2019, for the admission of additional exhibits. Melissa Speed represented Ergle. Alla Mintzer Zaprudsky represented the State.

The parties submitted post-hearing briefs on February 14, 2020. After considering the evidence and arguments of the parties, I propose the following:

FINDINGS OF FACT

Sheri Ergle is an RTW at IVH. She has worked at IVH since October 13, 1997. IVH is a 447-bed nursing facility that provides care for Iowa's veterans. The facility has around one hundred memory-care beds, and the rest are general nursing care. The facility operates using a philosophy of person-centered care. Using this philosophy, IVH strives to provide a continuum of care to Iowa's veterans and their spouses in an environment focused on individualized services to enhance their quality of life. This approach allows the staff to help residents guide and direct their own care. Residents have rights including the right to refuse care.

At all times relevant to this appeal Ergle worked at Ulery West, which is a 30-bed memory care unit. The facility assigns staff to this building that are trained to work with dementia and memory care residents. Staff are trained that a person's nonverbal interaction and body language are key components of communication for residents with dementia as those residents may struggle to find the words necessary to communicate. When providing care for residents with dementia, IVH expects RTWs to communicate both verbally and visually with the resident before touching the resident.

The State requires RTWs at IVH to attend twelve hours of education annually. Certain classes are required for all staff, while the rest of the hours are based on the needs of the RTWs. Staff that work with residents with dementia

are required to attend six hours annually of education specifically tailored to working with residents with dementia.

The training the RTWs received in the recent years leading up to this incident include specific training on Chronic Confusion or Dementing Illness. This training discusses that when approaching someone with dementia, the staff should get down to the resident's level and speak slowly. The staff should only make one statement at a time and allow the resident time to process the statement. If the resident does not understand, that resident will likely become aggressive. RTWs are taught to let a resident have a sense of control and structure. RTWs need to give the resident simple choices and provide single step directions. The training informs the staff to ask the resident to assist with that resident's care, and to wait for the resident's response before proceeding.

Before assisting a resident, RTWs are to refer to a resident's care plan or directive. The facility continually updates the care plan. The care plan provides vital information about the resident's medical needs, as well as tips for working with the resident. The resident's care plan is located in the resident's room.

Ergle has worked at IVH for twenty-two years. Her supervisors have given her positive evaluations and Ergle's attendance is perfect. Ergle has had no discipline in the ten years prior to the incident at issue in this case.

Ergle received the Iowa Commission of Veterans Affairs Code of Conduct and Work Rules, Home Compliance and Ethics plan, Code of Ethics and Conduct policy, and the State of Iowa Employee Handbook. Ergle transferred to Ulery in

2015 so she has received extensive training on caring for residents with dementia. Ergle also had training on residents' rights.

The discipline at issue in this case stems from an alleged incident with Resident L who lives in Ulery West, Unit 5. Resident L has dementia, is hard of hearing, and uses a hearing aid. The resident's care plan specifically states to make sure this resident hears you. The resident requires a two-person assist. His care plan also says he may become depressed and can yell and strike out during staff interventions. Resident L's care plan directs RTWs to redirect and reapproach this resident with different wording if needed when providing care. The care plan states that if Resident L becomes combative, the RTW should contact a licensed staff member for assessment and further interventions. The staff, including Ergle, knew this resident had a history of being combative and often refused cares and showers. The resident often acted combative when he did not hear or understand something.

On August 23, 2018, Ergle was assigned to work on Unit 5 in Ulery West, her normally assigned unit. She worked the second shift, approximately 6:15 p.m. to 6:15 a.m.

That evening, IVH assigned one RTW and one LPN or charge nurse to each unit. On Unit 5, Ergle was the assigned RTW and Lydia Herzberg was the assigned LPN. On Unit 4, Wiley Ahn was the assigned RTW and Karla Ramirez was the assigned LPN. Tricia Weber was the assigned RTW float between the two units to help with any tasks needed. Ahn and Ergle, as the assigned RTWs in the unit, were in charge of caring for the residents in their unit, ensuring the

residents were fed, assisting the residents into bed, and anything else that was needed. The staff carried cell phones in order to be able to contact one another when assistance was needed.

When Ergle arrived for her shift that evening, she checked in with the RTW from the previous shift to see how the residents were doing. Herzberg, her charge nurse for the evening told her that Resident L still needed a shower. Ergle had two residents that were scheduled for showers that night. Herzberg helped Ergle with the first resident's shower. Herzberg then had other matters to take care of and said she would call the float RTW, Weber, for the second shower.

When Weber arrived, Ergle told her that she needed assistance with a shower for Resident L. Weber said she had assisted with a shower for Resident L a few days earlier and it did not go well. Weber told Ergle she would ask Ahn to come help instead. When Ergle told Herzberg about the exchange, Herzberg said she had heard that Resident L had slapped someone's glasses off their face. That information concerned Ergle as she wears glasses and cannot see when she is not wearing them. Nonetheless, Herzberg told Ergle that she still had "to try" to give Resident L a shower.[1]

The incident at issue took place shortly before 8:00 p.m. Ahn came over to Ulery West Unit 5 to assist Ergle with Resident L's shower. Ergle gathered the equipment needed for providing care to the resident. The RTWs went into the room with the necessary equipment.

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[1] If Resident L had refused a shower, the staff had other options available including a bed bath, or waiting until the next shift.

Resident L was sitting in the reclining chair in the corner of his room. He was wearing a t-shirt and a button down shirt that was unbuttoned. The window was on the resident's left side and his bed was on his right side. After some introductory comments and tasks, Ergle went to stand by the resident's left side and Ahn stood on the resident's right side. The resident had a catheter bag on the left side, and Ergle had to move carefully to avoid it.

Ergle planned to approach the resident with progressive one-step directions. She also considered her word usage and determined telling the resident of the intent to provide him with a shower was not the best course of action. Prior to beginning her discussion with the resident on cleaning him up, Ergle told Ahn that it would be easier to get the resident's shirt off while he was still in the chair, as they would need to put him in bed to remove his other clothes, and it is difficult to remove his shirt when he is in bed.

While on the resident's left side, Ergle leaned in to the resident and said, "We're getting ready to clean you up. Is that okay?" Ergle then asked if she could untuck the resident's shirt. Resident L leaned forward. Ergle believed that meant he consented to her untucking his shirt. Once Ergle had the left side of Resident L's shirt removed from his pants and had lifted the bottom of the shirt up, she stepped back carefully to avoid the catheter. Ergle intended on asking the resident if he would help her remove his arm from his sleeve at that time because she could not proceed to take the shirt off without the resident's assistance.

During the time it took Ergle to untuck the resident's shirt from his left side, Ahn had been attempting to remove the resident's shirt from his right side.

It is unclear from the record whether Ahn removed the shirt completely from the resident's right shoulder or whether Ahn merely pulled the shirt off the resident's shoulder so it was resting tightly on his upper arm.

When Ergle stepped back, she saw that Resident L was agitated and had Ahn's wrist and thumb. The resident was yelling at Ahn. Ergle never proceeded any further with removing the resident's shirt. Both Ergle and Ahn stated they did not proceed after the resident expressed his refusal. After the resident finally released Ahn, Ergle noticed the resident had a skin tear on his right hand. Ergle alerted Ahn to the skin tear. Although the record is unclear where the button-down shirt was on the resident's right side at that moment, Ergle was able to see the resident also had skin tears on the triceps area of his arm. The resident continued yelling at Ahn.

Ergle told Ahn they needed to report the incident. Ergle walked away from the resident and into the hall to call the charge nurse. The resident had been yelling for approximately two minutes before Ergle called the charge nurse. Ergle first called Herzberg, who was in the room across the hall and could hear the resident yelling. Ergle told Herzberg the resident had skin tears. Herzberg was busy and could not assist so Ergle called the charge nurse in Ulery West 4, Ramirez. Ergle told Ramirez that Herzberg would need her help, but did not tell Ramirez at that point about the incident with Resident L or about the skin tears.

Ergle and Ahn waited in the hall for Ramirez to arrive. The resident continued yelling. About five minutes after the resident first started yelling, Ramirez came to assist the RTWs. The resident calmed down when Ramirez

appeared. The resident told Ramirez that Ahn had hurt him and he wanted him fired. Ergle tried to explain to Ramirez what had happened, but Ramirez waved her off as she felt the resident was listening and would become agitated again. At that point, Ergle felt she was dismissed. She took the washrag and other laundry out of the room. Both Ergle and Ahn contend that they did not remove the resident's shirt at any point during this incident. Ahn claims the shirt was off the right arm, but was still on the left arm of the resident's body. Ergle claims the shirt was pulled down on the right arm, but was still on the left arm. Ergle assumed Ramirez took the shirt off when getting the resident cleaned up. After Ramirez and Herzberg came upon the scene, Ergle and Ahn went back to other tasks.

The resident was upset about the incident and reported this to staff the next day. A nurse alerted management on August 24 about the incident. In the resident's statement, he said, "They wanted me to change my shirt and I said no. That guy that's been here for 20 years grabbed my shirt and took it off. I said I wasn't changing my shirt. Then he threw it on the floor and left." The incident was reported to the Department of Inspections and Appeals, but that department chose not to investigate.

Melissa Sienknecht, the Public Service Manager opened an investigation on August 24. Sienknecht began the investigation by interviewing the two LPNs on duty that night, Ramirez and Herzberg. Management interviewed Ramirez and Herzberg the afternoon of August 24. Management interviewed Ergle and Ahn on August 25, and the RTWs were placed on administrative leave at that time. On

August 27, Ergle sent Nikki Betz, the Ulery building supervisor who was one of the interviewers during the investigation, a text to clarify pieces of her first interview. Management interviewed Herzberg again on August 28. Management interviewed Ergle and Ahn again on August 30. Sienknecht also reviewed the resident's care plan and the surveillance video.

When reviewing the interviews, management claimed Ergle's recollection of events was not credible as she was not consistent in her retelling of the incident. The State claims that Ergle's description of her participation in the matter, how she and Ahn were removing the shirt, who was in the room at what time, and her estimates about the length of time of the incident were inconsistent. In reviewing the record, there is inconsistency on the exact details of what occurred on August 23. There are also inconsistencies within Ergle and Ahn's individual recollection of events. These inconsistencies are not out of the ordinary when interviewing individuals that were trying to remember minutiae of what occurred with one resident days before when the witnesses had cared for other people afterwards. I do not find it abnormal to fail to remember particular details such as where the shirt was, who was in the room first, or whether someone waited in the hallway or in the room.

Despite the inconsistent statements from the witnesses, the interviews yield the following facts. Ergle told the resident generally what was going to happen. The record is unclear on the exact wording Ergle used, but in all retellings of the events of that evening Ergle told Resident L they were going to get him cleaned up. Ahn confirms that Ergle told the resident they were going to

get him cleaned up and said something about the resident's shirt. I find that Ergle communicated with the resident about what was going to occur and did so using an approach suited to those with dementia. She used simple directions, engaged the resident in assisting with his own care, and used one-step directions.

Further, I find that Ergle asked the resident if she could untuck his shirt, and Ergle reasonably believed the resident understood her. In Ergle's first interview, when asked whether she communicated with the resident about what they were doing and whether he understood, Ergle said the resident "didn't actually react," but she assumed he understood her. Ahn also says in his interviews that Ergle was talking loudly enough for Resident L to hear, but he did not know whether Resident L understood what was happening.

However, prior to Ergle's first interview she had recounted the events of that night to Herzberg. In Herzberg's first interview, she confirmed that Ergle had said she asked the resident whether she could untuck his shirt and he leaned forward. After her first interview, Ergle in all subsequent retellings of the event says she asked to untuck the resident's shirt and he leaned forward. She reasonably believed she obtained the resident's consent for her action of untucking his shirt. I do not find Ergle's concern about whether the resident understood her in the first interview to be inconsistent with her statement to Herzberg and her subsequent statements that she believed Resident L consented because he leaned forward. She relied on nonverbal communication from the

resident, as she was taught to do at her training on working with residents with dementia.

I also find the record absent of credible evidence that Ergle failed to stop when Resident L refused care. Both Ahn and Ergle state they stopped when Resident L expressed his refusal verbally and nonverbally. Ergle states she could not proceed, as she would not have been able to get the shirt over Resident L's shoulder without his assistance.

Management found that both Ahn and Ergle proceeded to remove the shirt despite the resident's refusal. This is inconsistent with the record. Ergle claims she only untucked the resident's shirt and then stopped. Ahn confirms the shirt was still on the left arm, where Ergle was assisting the resident. Herzberg confirms in her interview that Ergle told her the resident allowed them to remove the shirt to the armpit area, but then started yelling. Although Ahn and Ergle's statements are inconsistent about whether the shirt was on or off the right arm, I find Ergle did not remove the shirt from the resident's left side beyond untucking the shirt from the resident's pants.

Management relied on the statements of the LPNs who responded to the incident in determining the resident's shirt was off, and Ergle and Ahn had removed it. Ramirez arrived on the scene first. In her interview, she stated she could not remember whether the shirt was on or off as she was focused on the injury. She thinks the shirt was off, but she did not make a definitive statement. Herzberg, who arrived several minutes later, said the resident's shirt was removed prior to when she entered the room.

Management may have also relied on the resident's statement that Ahn removed his shirt and threw it on the floor. The record does not provide an explanation for when or who took the resident's statement. It is clear the statement was not taken until at least the day after the incident. Also, Ramirez and Herzberg say the resident told them that Ahn hurt him and he wanted him fired. However, neither Herzberg nor Ramirez mentioned the resident telling them that Ahn removed the resident's shirt. Without corroboration, it is difficult to rely on the resident's statement.

Even if management believed the resident's recollection and Ramirez's uncertain belief that the shirt was removed prior to her entering the room, the record still does not contain any indication that Ergle either removed the shirt or knew how the shirt was removed. There were only three people in the room during the initial incident. Neither Ahn, Ergle, nor the resident ever contend that Ergle removed the resident's shirt. As the record contains no evidence that Ergle did more than untuck the resident's shirt after she believed he had consented, I cannot find that Ergle proceeded to remove the shirt over the resident's protest.

Finally, I find the record contains no evidence that Ergle caused the resident's injury. All the witnesses in this case confirmed the skin tears were on the resident's right arm and hand. The witnesses also confirmed that Ahn was on the right side of the resident, while Ergle was on the left side. Additionally, Ramirez and Herzberg confirmed that Resident L yelled at and about Ahn, but never mentioned Ergle.

After conducting the investigation both Sienknecht and Sarah Bruner, the administrator of nursing, were involved in the determination of Ergle's discipline. After reviewing the interviews, management did not find Ergle's statements credible. Management determined that Ergle acted outside the expectations of her position when she failed to make sure the resident understood what was happening and then did not stop when the resident became agitated and refused care. Management determined that Ergle and Ahn must have proceeded to provide care despite refusal after finding that Ergle and Ahn removed the resident's shirt.

Management found a five-day paper suspension to be the appropriate discipline for both Ergle and Ahn. Management determined that progressive discipline was not entirely applicable due to the egregiousness of the situation as shown by the severity of the injury and the RTWs' failure to follow person-centered care. Management stated Ergle failed to follow person-centered care when she failed to tell the resident and make sure he understood what was happening, continued to take off the resident's shirt after he became combative, and acted in a manner that resulted in injuries to the resident. Management contends it did consider other similar situations in which employees admitted to personal degradation or abuse of a resident. In those other circumstances, management also skipped lesser progressive discipline steps.

The State issued Ergle the five-day suspension and final warning on September 6, 2018. In the letter, the State pronounced the reason for the corrective action was because "On August 23, 2018 your conduct was

disrespectful and you did not follow resident centered care leading to a resident injury." The letter never specifies precisely what actions Ergle did or failed to do that led to the discipline. In the letter, the State provides that Ergle's actions were in violation of the Commission of Veterans Affairs Work Rule B2. That rule states:

> B. PERFORMANCE OF DUTIES
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> . . . .
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> 2. You are expected to work cooperatively with other employees, residents and all others involved with the Commission's work. You will treat other employees, residents, guests, visitors and the public with respect, dignity courtesy and fairness. You will comply with Iowa's dependent adult abuse requirements, including reporting abuse. You shall not abuse, neglect or exploit residents, whether verbally, physically, sexually or financially.

Ergle appealed her discipline by filing a grievance with DAS on September 7, 2018. Ergle wrote an explanation of events to the DAS representative. In her explanation, she discusses her failure to contact a supervisor about the incident, which demonstrated she was still unaware of the precise reasons for discipline. DAS issued a third-step response on October 10, 2018. DAS reduced the five-day suspension to a three-day suspension because of Ergle's unblemished record and length of service. Nonetheless, DAS agreed with IVH that suspension was appropriate because Ergle did not clearly notify the resident of the care he was to receive and did not heed the resident's request to stop.

Ergle filed the present appeal on October 16, 2018. Ergle alleges the State has not shown just cause for any discipline, as the State has not proven that she violated a rule. Ergle contends IVH lacks credible evidence of the allegation made, and the decision to issue discipline was without just cause and based on the

assumptions and biases of the investigators. Ergle also argues the resident at issue in this incident has had many other subsequent incidents with other staff, some resulting in injury, but no other staff member has been disciplined.

The State argues that Ergle's recollection of events is not credible as it is inconsistent. The State contends just cause exists for the issuance of the three-day suspension.

CONCLUSIONS OF LAW

Ergle filed this appeal pursuant to Iowa Code section 8A.415(2), which states:

> 2. *Discipline Resolution*
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> *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.
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> *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.

DAS rules provide 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 of the agency of employment, conviction of a crime involving moral turpitude, conduct unbecoming a public employee, misconduct, or any other just cause.
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> . . . .
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> 60.2(1)(b) Disciplinary suspension. An appointing authority may suspend an employee for a length of time considered appropriate not to exceed 30 calendar days . . . . A written statement of the reasons of the suspension and its duration shall be sent to the employee within 24 hours after the effective date of the action.

The State bears the burden of establishing that just cause supports the discipline imposed. *Phillips and State of Iowa (Dep't of Human Res.)*, 12-MA-05 at App. 11. The term "just cause" when used in section 8A.415(2) and in administrative rule is undefined. *Stockbridge and State of Iowa (Dep't of Corr.)*, 06-MA-06 at 21 (internal citations omitted). Determination of whether management has just cause to discipline an employee requires case-by-case analysis. *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. The Board has stated the 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. Although just cause requires examination on a case-by-case basis, the Board has declared the following factors may be relevant to the just cause determination:

> 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. The Board has also considered how other similarly situated employees have been treated. *Kuhn and State of Iowa (Comm'n of Veterans Affairs)*, 04-MA-04 at 42.

PERB has determined the presence or absence of just cause rests on the reasons stated in the disciplinary letter. *Eaves and State of Iowa (Dep't of Corr.)*, 03-MA-04 at 14. Iowa Code section 8A.413(19)(*b*) and DAS rule require the State to provide the employee being disciplined with a written statement of the reasons for the discipline. *See Hunsaker and State of Iowa (Dep't of Emp't Servs.)*, 90-MA-13 at 46, n.27. In order 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.

The State has not shown just cause exists for a three-day suspension as the State has not demonstrated that Ergle violated a work rule. In the suspension letter, the State alleges Ergle violated the work rule that requires the staff to treat residents with respect, dignity, courtesy, and fairness. The State contends Ergle violated the rule when she failed to properly notify Resident L that she planned to remove his shirt and give him a shower, when she continued to remove Resident L's shirt despite his refusal, and when she caused injury to the resident. The State does not have sufficient proof to support these allegations.

The credible evidence demonstrates that Ergle reasonably believed she explained and the resident understood her intent to untuck his shirt from his pants. Both Ergle and Ahn stated that Ergle was speaking in a voice loud enough for the resident to hear her even though he was hard of hearing. The only question is whether he understood her. Although in Ergle's first interview she stated the resident "didn't actually react" when she asked to untuck his shirt, she had previously told Herzberg the resident leaned forward, and her subsequent statements confirm this. These statements explain why Ergle said in that first interview that she assumed the resident understood her. He did react, just not verbally. Ergle's statement given near the time of the event to Herzberg and Ergle's subsequent statements demonstrate that Ergle made the request to the resident to untuck his shirt, and the resident consented. Ergle gave the resident proper notice for the action she took to untuck his shirt.

The State contends that Ergle did not explain to the resident that she intended to remove his shirt, and her failure to do so equates to a rule violation. Ergle has credibly explained that she was progressing slowly, using one-step directions as her training dictated. Ergle did not request to remove the resident's shirt at the time because she had not reached that step yet.

Although Ahn began to remove the resident's shirt, the State has not demonstrated that Ergle should be disciplined for her failure to tell the resident about what another RTW was going to do. The record does not support a finding that Ergle knew Ahn intended to remove the shirt at that moment or had time to stop him from doing so. After Ergle untucked the resident's shirt, she saw that Ahn and the resident were struggling and the resident's shirt was at least partially removed on the right side. The record demonstrates the only action Ergle took was to untuck Resident L's shirt from his pants. The State has not provided sufficient proof that Ergle failed to notify the resident about her intent to untuck his shirt. As there is insufficient proof that Ergle failed to notify the resident about her actions, the State has not shown a rule violation on this basis.

The State has also not shown that Ergle continued to provide care to the resident after his refusal in violation of the work rule. The record contains evidence that Ergle untucked the resident's shirt. The record contains a lot of discussion about whether the resident's shirt was on or off and when the shirt was fully removed. However, there is no evidence that Ergle took any further action to remove the shirt after she untucked the shirt from the resident's pants and the resident began to protest. Management interviewed Ahn, Herzberg, and

Ramirez, and none of them claimed that Ergle removed the resident's shirt after the resident protested. The record contains the statement the resident made after the incident and the comments he made to the RTWs and LPNs. Resident L's statements as contained in the record do not indicate he felt that Ergle had continued to remove his shirt after he refused. He laid the entire blame on Ahn. As the record contains no evidence that Ergle removed the resident's shirt, the State has not shown Ergle violated the rule by removing the resident's shirt after his refusal.

Finally, the State also contends that skipping the steps of progressive discipline was necessary because Ergle contributed to the resident's injury. Regardless of the State's determination that Ergle's narrative of events was inconsistent and not credible, Ahn, Ergle, Herzberg, and Ramirez all stated that Ergle was on the resident's left side, while the resident's injury was on his right hand and arm. The resident expressly blamed Ahn, not Ergle. The State has not demonstrated that Ergle caused or contributed to the resident's injury.

The State has not shown with sufficient proof that Ergle failed to treat Resident L with respect, dignity, courtesy and fairness. As such, the State has failed to demonstrate with sufficient proof that Ergle engaged in actions or omissions, which were in violation of the rule cited in the letter of discipline. The State cannot demonstrate just cause existed for any discipline without sufficient proof of a rule violation.

I consequently propose the following:

ORDER

The State of Iowa, Iowa Veterans Home, shall rescind and remove the original and all copies of the notification of Sheri Ergle's suspension, as well as any other documentation of the suspension from all personnel files maintained concerning Ergle. The State shall take all other actions necessary to place Ergle in the position she would have been in had the State not issued a suspension on September 6, 2018.

The costs of reporting and of the agency-requested transcript in the amount of $949.75 are assessed against the Appellee, State of Iowa, pursuant to Iowa Code section 20.6(6) and PERB rule 621—11.9. A bill of costs will be issued to the Appellee in accordance with PERB subrule 621—11.9(3).

The proposed decision and order will become PERB's final agency action on the merits of Ergle's appeal pursuant to PERB rule 621—9.1 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 merits.

DATED at Des Moines, Iowa this 31st day of March, 2020.

/s/ Amber DeSmet

Administrative Law Judge

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Parties served via eFlex.