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STATE OF MICHIGAN

CIRCUIT COURT FOR THE COUNTY OF OAKLAND

MICHIGAN NURSES ASSOCIATION, DONNA CROSS, JANET HOOVER, ANN KASTELEN, KATHLEEN LEHMAN, JUDY MOORE, JULIE SKIDMORE, and JENNIFER VELLA,

Plaintiffs,

-vs-

VHS HURON VALLEY-SINAI HOSPITAL, INC., d/b/a HURON VALLEY-SINAI HOSPITAL,

Defendant.

2017-161813-CZ
JUDGE MARTHA ANDERSON

Case No. 17- -CZ

Hon. _____

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COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the Complaint.

NOW COME Plaintiffs, the Michigan Nurses Association, Donna Cross, Janet Hoover, Ann Kastelen, Kathleen Lehman, Judy Moore, Julie Skidmore, and Jennifer Vella, by and through their attorneys, White Schneider PC, and for their complaint against Defendant, VHS Huron Valley-Sinai Hospital, Inc., d/b/a Huron Valley-Sinai Hospital, state as follows:

PARTIES, JURISDICTION, AND VENUE

1. Plaintiff, Michigan Nurses Association ("MNA"), is a professional non-profit association and labor organization, with its principal office located in Ingham County, Michigan.

2. MNA is the exclusive bargaining representative for all full-time, regular part-time, and contingent registered nurses ("RNs") employed by Defendant at its health facility located in Oakland County, Michigan.

3. Plaintiffs Donna Cross, Janet Hoover, Ann Kastelen, Kathleen Lehman, Judy Moore, Julie Skidmore, and Jennifer Vella (collectively "Nurses") are members of MNA and employed with Defendant as RNs at Defendant's facility located in Oakland County, Michigan.

4. Defendant, VHS Huron Valley-Sinai Hospital, Inc. is a foreign profit corporation, incorporated under the laws of Delaware. Defendant applied for and was granted authority to transact business in Michigan in 2010. Defendant conducts business under several assumed names in Michigan including, but not limited to, Huron Valley-Sinai Hospital. Defendant owns and operates a health facility in Oakland County, Michigan ("Defendant's facility").

5. Jurisdiction is proper in this Court pursuant to the Revised Judicature Act, specifically, MCL 600.601, 600.605, 600.701, 600.705 and 600.711(3), as the claim is for equitable and declaratory relief and Defendant carries on business within the state.

6. Venue is proper in this Court pursuant to the Revised Judicature Act, specifically MCL 600.1621(a), as the Defendant has a place of business and conducts business in Oakland County, as well as MCL 600.1627 because all or a part of the cause of action arose in Oakland County.

7. This Complaint requests a declaratory judgment and equitable relief regarding a hospital's obligation under the Public Health Code, MCL 333.1101 *et seq*, and specifically, MCL 333.20180, to accept and respond to written reports of unsafe practices or conditions existing within the hospital.

FACTS

8. Plaintiffs incorporate by reference paragraphs 1 through 7 as if fully set forth herein.

9. Defendant is licensed to operate a health facility by the Department of Licensing and Regulatory Affairs ("LARA"), pursuant to Article 17 of the Michigan Public Health Code ("Code"), 1978 PA 368, MCL 333.1101, *et seq*; MSA 14.15(1101), *et seq*.

10. Defendant's facility ("Hospital") is licensed for 158 beds.

11. The Nurses use their professional medical judgment to provide each patient with a safe environment, to periodically perform assessments of patients, and put in place those methodologies that, based on their individual experience, will provide a safe environment for patients while in the care of the Hospital.

Plaintiff Kathleen Lehman Reported an Unsafe Practice or Condition

12. On January 17, 2017, Plaintiff Kathleen Lehman ("Nurse Lehman") worked as the primary nurse at the Hospital for the afternoon shift (3:00 p.m. to 11:30 p.m.) in the Emergency Department, an acute care unit.

13. On said date, Nurse Lehman verbally protested her work assignment to her manager as given to her by the Charge Nurse on the unit. Nurse Lehman's objection was based on her professional assessment of the following unsafe work conditions:

(a) inadequate nurse-to-patient ratios for patient acuity based on her clinical judgment; and

(b) the unit was not staffed with an adequate number of support staff.

14. Nurse Lehman asked management to make arrangements for more nursing staff to come to the unit to help with the high acuity patients. On information and belief, no such arrangements were made by management of the Hospital.

15. At the beginning of her shift, Nurse Lehman was assigned to care for seven patients, one (1) of whom required one-on-one nursing care. Before her shift ended, multiple patients came into the unit requiring triage. All other nurses on the unit at the time were assigned to care for five (5) to six (6) patients. The Hospital had no patient care assistants or emergency department technicians assigned to the unit during said shift who could assist Nurse Lehman.

16. Nurse Lehman protested said work assignment because in her professional judgment it was an unsafe practice or condition, thereby placing her professional nursing license, her own physical safety, and the care and safety of Hospital patients at risk. More specifically, Nurse Lehman believed that her work assignment, combined with the work assignments of the other nurses on duty and lack of sufficient Hospital staff during her shift, was likely to lead to:

(a) medication errors, including the late administration of medications to Hospital patients; and

(b) inadequate time to properly assess, evaluate, and monitor or observe patients assigned to her care.

17. Nurse Lehman's manager made no adjustment to her work assignment that alleviated said safety and licensing risks.

18. Nurse Lehman completed a written notice of these unsafe practices

and conditions, a copy of which is attached as Exhibit A.

19. Nurse Lehman attempted to deliver this written notice to her manager, Julie Calley. Ms. Calley refused to accept receipt of the written notice.

20. The Hospital took no action to address these unsafe practices or conditions.

21. Nurse Lehman provided care to the patients she was assigned to the best of her ability, fearful for the safety of the patients and herself, and of the negative consequences that would result if she was unable to perform her professional duties in accordance with acceptable standards of nursing practice because the Hospital ignored her complaint.

Plaintiff Donna Cross Reported an Unsafe Practice or Condition

22. On February 15, 2017, Plaintiff Donna Cross ("Nurse Cross") worked as the primary nurse at the Hospital for the morning shift (7:00 a.m. to 3:00 p.m.) on the West Side Intensive Care Unit, a so-called step-down intensive care unit.

23. On this date, Nurse Cross verbally protested her work assignment to her manager. Nurse Cross's objection was based on her professional assessment of the following unsafe work conditions:

(a) inadequate nurse-to-patient ratios for patient acuity based on her clinical judgment;

(b) the unit was not staffed with an adequate number of support staff; and

(c) the RNs were not oriented to or experienced in the area they were assigned.

24. During her shift on said date, Nurse Cross was pulled from her unit to work in another unit.

25. Nurse Cross protested said work assignment because in her professional judgment it was an unsafe practice or condition, thereby placing her professional nursing license, her own physical safety, and the care and safety of Hospital patients at risk. More specifically, Nurse Cross believed that her work assignment, combined with the work assignments of the other nurses on duty and the lack of sufficient Hospital staff during her shift, was likely to result in:

(a) delayed or incomplete medical record documentation;

(b) inadequate time to properly assess, evaluate, monitor, or observe the patients assigned to her care; and

(c) cause her to be unable to meet acceptable nursing standards of care including, but not limited to, reducing the risk of patients developing pressure ulcers (commonly known as bedsores).

26. Nurse Cross's manager made no adjustment to her work assignment that alleviated said safety and licensing concerns.

27. Nurse Cross completed a written notice of the unsafe practices and conditions, a copy of which is attached as Exhibit B.

28. Nurse Cross attempted to deliver this written notice to her manager. The Hospital's manager refused to accept receipt of the written notice, stating, "I'm not allowed to touch these forms."

29. The Hospital took no action to address said unsafe practices or conditions.

30. Nurse Cross provided care to the patients she was assigned to the best of her ability, fearful for the safety of the patients, her own personal safety, and the negative consequences that would result if she was unable to perform her professional

duties in accordance with acceptable standards of nursing practice because the Hospital ignored her complaint.

Plaintiff Jennifer Vella Reported an Unsafe Practice or Condition

31. On February 17, 2017, Plaintiff Jennifer Vella ("Nurse Vella") worked as the primary nurse at the Hospital for the afternoon shift (10:00 a.m. to 6:30 p.m.) on the Post-Anesthesia Care Unit (also known as PACU), where nurses monitor and care for patients recovering from surgery.

32. Hospital Manager Sharlene Nova gave Nurse Vella her work assignment for said shift.

33. On said date, Nurse Vella verbally protested her work assignment to the manager on the unit. Nurse Vella's objection was based on her professional assessment that there was an inadequate nurse-to-patient ratio for patient acuity.

34. Nurse Vella protested said work assignment because in her professional judgment it was an unsafe practice or condition, thereby placing her professional nursing license, her physical safety, and the care and safety of Hospital patients at risk. Because they were understaffed, RNs were forced to work beyond their scheduled work shift. Had Nurse Vella left work at the end of her assigned shift, there would have been two (2) RNs for five (5) patients in the PACU. One of those patients had experienced an adverse event following surgery and required one-on-one nursing care.

35. The Hospital manager made no adjustment to her work assignment to alleviate said safety and licensing concerns.

36. Nurse Vella completed a written notice of the unsafe practices and

conditions, a copy of which is attached as Exhibit C.

37. Nurse Vella attempted to deliver this written notice to her manager. But, the Hospital's manager refused to accept receipt of the written notice, stating, "I cannot accept this form."

38. The Hospital took no action to address said unsafe practices or conditions.

39. Nurse Vella provided care to the patients she was assigned to the best of her ability, including remaining on duty until additional staff was available, fearful for the safety of the patients, herself, and the negative consequences that would result if she was unable to perform her professional duties in accordance with acceptable standards of nursing practice because the Hospital ignored her complaint.

Plaintiff Janet Hoover Reported an Unsafe Practice or Condition

40. On April 12, 2017, Plaintiff Janet Hoover ("Nurse Hoover") worked as the primary nurse at the Hospital for the day shift (7:30 a.m. to 4:00 p.m.) on the PACU.

41. On said date, Nurse Hoover verbally protested her work assignment to the manager on the unit. Nurse Hoover objected based on her professional assessment that there was an inadequate nurse-to-patient ratio for patient acuity. More specifically, the normal staffing for the PACU included eleven (11) RNs, two (2) aides/technicians, and one (1) clerk/secretary for forty-five (45) patients. On the day of her assignment for the day, the PACU had between six (6) and seven (7) RNs.

42. Nurse Hoover protested said work assignment because in her professional judgment it was an unsafe practice or condition, thereby placing her professional nursing license, her physical safety, and the care and safety of Hospital

patients at risk.

43. The Hospital manager, Amy Leasure, made no adjustment to the work assignment to alleviate said safety and licensing concerns.

44. Nurse Hoover completed a written notice of the unsafe practice and condition, a copy of which is attached as Exhibit D.

45. Nurse Hoover attempted to deliver said written notice to her manager but she refused to acknowledge receipt of the notice.

46. The Hospital took no action to address said unsafe practice or condition.

47. Nurse Hoover provided care to the patients she was assigned to the best of her ability, fearful for the safety of herself and the patients, and the negative consequences that would result if she was unable to perform her professional duties in accordance with acceptable standards of nursing practice because the Hospital ignored her complaint.

Nurse Lehman Made a Second Report of an Unsafe Practice or Condition

48. On May 16, 2017, Nurse Lehman worked as the primary nurse in the Emergency Department at the Hospital for the afternoon shift (11:00 a.m. to 12:30 a.m.).

49. The Clinical Coordinator for the unit gave Nurse Lehman her work assignment for said shift.

50. Nurse Lehman verbally protested her work assignment to the manager on the unit because, in her professional and clinical judgment, it presented the following unsafe work conditions:

(a) inadequate nurse-to-patient ratios for patient acuity;

(b) the unit was not staffed with an adequate number of support staff; and

(c) new patients were transferred, admitted, or discharged without adequate staff to care for them.

51. During her shift on said day, Nurse Lehman observed seven (7) to nine (9) patients waiting in triage for over two (2) hours. Additionally, there were between three (3) and five (5) patients who were labeled as "priority one."

52. Despite the understaffing, RNs were sent home during the shift and not called back to the unit by the Hospital.

53. Nurse Lehman protested said work assignment because in her professional judgment it was an unsafe practice or condition, thereby placing her professional nursing license, her physical safety, and the care and safety of Hospital patients at risk. More specifically, Nurse Lehman believed that her work assignment, combined with the work assignments of the other nurses on duty and the lack of sufficient Hospital staff during her shift, was likely to result in:

(a) medical errors, including late administration of medications;

(b) IVs running late or dry, and sub-Q IVs not being identified;

(c) inadequate time to properly assess, evaluate, monitor, or observe the patients assigned to her care; and

(d) delayed or incomplete medical record documentation.

54. The Hospital manager made no adjustment to the work assignment to alleviate said safety and licensing concerns.

55. Nurse Lehman completed a written notice of the unsafe practice and condition, a copy of which is attached as Exhibit E.

56. Nurse Lehman attempted to deliver said written notice to her

manager. The Hospital's manager, however, refused to accept receipt of the written notice.

57. The Hospital took no action to address said unsafe practice or condition.

58. Nurse Lehman provided care to the patients she was assigned to the best of her ability, fearful for the safety of the patients and the negative consequences that would result if she was unable to perform her professional duties in accordance with acceptable standards of nursing practice because the Hospital ignored her complaint.

Plaintiff Ann Kastelen Reported an Unsafe Practice or Condition

59. On May 27, 2017, Plaintiff Ann Kastelen ("Nurse Kastelen") worked as a registered nurse in the Emergency Department at the Hospital for the day shift (7:00 a.m. to 7:30 p.m.). The Hospital manager for the unit gave Nurse Kastelen her work assignment for said shift.

60. On said date, Nurse Kastelen verbally protested her work assignment to the manager on the unit because, in her professional judgment, it presented an unsafe work condition; specifically, inadequate nurse-to-patient ratios for patient acuity.

61. During her shift, Nurse Kastelen was assigned to care for a two-week-old infant who needed to be intubated. In Nurse Kastelen's professional judgment, the infant required the time and skills of two nurses.

62. Nurse Kastelen protested said work assignment because in her professional judgment it was an unsafe practice or condition, thereby placing her professional nursing license and the care and safety of Hospital patients at risk. More

specifically, Nurse Kastelen believed that her work assignment, combined with the work assignments of the other nurses on duty and the lack of sufficient Hospital staff during her shift, resulted in:

(a) inadequate time to properly assess, evaluate, monitor, or observe the patients assigned to her care; and

(b) delayed or incomplete medical record documentation.

63. The Hospital manager made no adjustment to the work assignment to alleviate said safety and licensing concerns.

64. Nurse Kastelen completed a written notice of the unsafe practice and condition, a copy of which is attached as Exhibit F.

65. Nurse Kastelen attempted to deliver said written notice to her manager. However, the Hospital's manager refused to accept receipt of the written notice.

66. The Hospital took no action to address said unsafe practice or condition.

67. Nurse Kastelen provided care to the patients she was assigned to the best of her ability, fearful for the safety of the patients and the negative consequences that would result if she was unable to perform her professional duties in accordance with acceptable standards of nursing practice because the Hospital ignored her complaint.

Plaintiff Julie Skidmore Reported an Unsafe Practice or Condition

68. On June 25, 2017, Plaintiff Julie Skidmore ("Nurse Skidmore"), worked as a primary nurse in the Intensive Care Unit at the Hospital for the day shift (7:00 a.m. to 7:00 p.m.). The manager for the unit gave Nurse Skidmore her work assignment.

69. On said date, Nurse Skidmore verbally protested her work

assignment to the manager on the unit based on her professional assessment of the following unsafe work conditions:

(a) the Charge Nurse responsibilities did not allow time for direct patient care assignments;

(b) the unit was not staffed with an adequate number of support staff; and

(c) new patients were transferred, admitted, or discharged without adequate staff to care for them.

70. During her shift, Nurse Skidmore observed high-acuity patients with no ancillary staff. And, Hospital management failed to call in a rapid response RN or other staff to assist with medical care or patient admissions.

71. Nurse Skidmore protested her work assignment because in her professional judgment it was an unsafe practice or condition, thereby placing her professional nursing license, her physical safety, and the care and safety of Hospital patients at risk. More specifically, Nurse Skidmore believed that her work assignment, combined with the work assignments of the other nurses on duty and the lack of sufficient Hospital staff during the shift, was likely to result in:

(a) medical errors, late administration of medications;

(b) delayed or incomplete medical record documentation;

(c) inadequate time to properly assess, evaluate, monitor, or observe the patients assigned to their care; and

(d) an inability to perform her duties in accordance with acceptable nursing standards to reduce the risk of patients assigned to her care from developing pressure ulcers (also known as bedsores).

72. The Hospital manager made no adjustment to the work assignment to alleviate said safety and licensing concerns.

73. Nurse Skidmore completed a written notice of the unsafe practice and condition, a copy of which is attached as Exhibit G.

74. Nurse Skidmore attempted to deliver said written notice to the Hospital manager. The Hospital's manager returned the written notice to Nurse Skidmore with no response. On information and belief, the manager did not make a copy of the written notice before returning it to Nurse Skidmore.

75. The Hospital took no action to address said unsafe practice or condition.

76. Nurse Skidmore provided care to the patients she was assigned to the best of her ability, fearful for the safety of the patients and herself, and the negative consequences that would result if she was unable to perform her professional duties in accordance with acceptable standards of nursing practice because the Hospital ignored her complaint.

Plaintiff Judy Moore Reported an Unsafe Practice or Condition

77. On June 20, 2017, Plaintiff Judy Moore ("Nurse Moore") worked as a primary nurse in the West Side Intensive Care Unit at the Hospital for the day shift (7:00 a.m. to 7:30 p.m.). The Hospital manager for the unit gave Nurse Moore her work assignment.

78. On said date, Nurse Moore verbally protested her work assignment to the manager on the unit because, in her professional judgment, it presented an unsafe work condition; specifically, the unit was not staffed with an adequate number of support staff.

79. On said day, Nurse Moore's supervisor told her that she was to orientate a float pool nurse who had no access to the Omnicell (an automated medication dispensing system). The patients the Hospital assigned to Nurse Moore included one (1) patient who was in respiratory distress, a patient with high blood pressure, a patient who was suicidal, and two (2) patients who were physically violent. During her assigned shift, the patient in respiratory distress was transferred to the intensive care unit, but an additional patient was admitted to the ICU from surgery for abdominal aortic aneurysm repair (commonly referred to as triple A repair), and security needed to be called to assist with the suicidal patient.

80. Nurse Moore protested said work assignment because in her professional judgment it was an unsafe practice or condition, thereby placing her professional nursing license, her physical safety, and the care and safety of Hospital patients at risk. More specifically, Nurse Moore believed that her work assignment, combined with the work assignments of the other nurses on duty and the lack of sufficient Hospital staff during her shift, resulted in:

(a) inadequate time to properly assess, evaluate, monitor, or observe the patients assigned to her care;

(b) delayed or incomplete medical record documentation;

(c) the risk of medication errors and late administration of medications; and

(d) Nurse Moore being prevented from meeting the teaching and discharge needs identified by the patients' care plans and conditions.

81. The Hospital manager made no adjustment to the work assignment to alleviate said safety and licensing concerns.

82. Nurse Moore completed a written notice of the unsafe practice and

condition, a copy of which is attached as Exhibit H.

83. Nurse Moore attempted to deliver said written notice to her manager. The Hospital's manager, however, refused to accept the written notice.

84. The Hospital took no action to address said unsafe practice or condition.

85. Nurse Moore provided care to the patients she was assigned to the best of her ability, fearful for the safety of herself and the patients, as well as the negative consequences that would result if she was unable to perform her professional duties in accordance with acceptable standards of nursing practice because the Hospital ignored her complaint.

Nurse Moore Made a Second Report of an Unsafe Practice or Condition

86. On July 9, 2017, Nurse Moore made a second report of an unsafe practice or work condition at the Hospital.

87. On said date, Nurse Moore worked in the Intensive Care Unit at the Hospital for the day shift (7:00 a.m. to 7:30 p.m.). The Hospital supervisor for the unit, Katie Davis, gave Nurse Moore her work assignment.

88. On said date, Nurse Moore verbally protested her work assignment to the manager on the unit because, in her professional and clinical judgment, it presented an unsafe work condition. Specifically, the unit was not staffed with an adequate number of support staff and there was an inadequate nurse-to-patient ratio for patient acuity.

89. The patients the Hospital assigned to Nurse Moore included two (2) quadriplegics, both of whom had a tracheostomy tube placed in their windpipe and one of whom was on a ventilator. Frequent suction was required for both patients.

90. Another patient the Hospital assigned to Nurse Moore during said shift included a bariatric patient needing a blood transfusion. The physician for said patient had instructions for the assigned nurse to walk with the patient to get the patient mobile. Said patient also required nursing care for pain management. While caring for one (1) patient, the alarm on the ventilator for one of the quadriplegic patients went on, which required someone to immediately respond to determine the problem and make sure the patient was safe. Nurse Moore was unable to respond to the alarm because she was with another patient who required immediate nursing care.

91. Nurse Moore protested said work assignment because in her professional judgment it was an unsafe practice or condition, thereby placing her professional nursing license, her physical safety, and the care and safety of Hospital patients at risk. More specifically, Nurse Moore believed that her work assignment, combined with the work assignments of the other nurses on duty and the lack of sufficient Hospital staff during her shift, resulted in:

(a) inadequate time to properly assess, evaluate, monitor, or observe the patients assigned to her care;

(b) delayed or incomplete medical record documentation;

(c) created the risk of medication errors and late administration of medications and subcutaneous (infused under the skin) intravenous IVs were not identified; and

(d) Nurse Moore being unable to meet the teaching and discharge needs identified by the patients' care plan and conditions.

92. The Hospital manager made no adjustment to the work assignment to alleviate said safety and licensing concerns.

93. Nurse Moore completed a written notice of the unsafe practice and

condition, a copy of which is attached as Exhibit I.

94. Nurse Moore attempted to deliver said written notice to her manager, Mike Leahy. Once again, the Hospital's manager refused to accept the written notice.

95. The Hospital took no action to address said unsafe practice or condition.

96. Nurse Moore provided care to the patients she was assigned to the best of her ability, fearful for the safety of herself and the patients, and the negative consequences that would result if she was unable to perform her professional duties in accordance with acceptable standards of nursing practice because the Hospital ignored her complaint.

Numerous Other Reports of Unsafe Practices or Conditions

97. Between January 1, 2017 and September 1, 2017, registered nurses represented by the Michigan Nurses Association attempted to submit to the Defendant over two hundred forty (240) written notices documenting unsafe practices and conditions existing within the hospital. In addition to the specific reports identified in ¶¶ 12-96, the written notices collectively document patient falls, numerous instances of late medications, the failure to deliver basic hygiene and human care to patients, including the failure to bathe patients sitting in urine and feces, patients being left unattended during critical situations, nurses being assigned to patients or units without proper training, equipment failures, and over one hundred sixty (160) instances of nurses working without breaks or lunches, or being forced to work overtime despite the impact on patient care. In all instances, the Defendant refused to accept or provide a written response to these reports of unsafe practices and conditions.

COUNT I

DEFENDANT VIOLATED THE MICHIGAN PUBLIC HEALTH CODE

98. Plaintiffs incorporate by reference Paragraphs 1 through 97 as if fully set forth herein.

99. Pursuant to section 20180 of the Public Health Code ("Code"), employees who provide the Department of Licensing & Regulatory Affairs ("LARA") with notice of unsafe practices or conditions existing within a hospital are eligible for immunity from civil and criminal prosecutions, and are protected from discharge or other forms of employment discrimination, provided the person making the report satisfies all of the conditions specified in that section, which states as follows:

> Except as otherwise provided in subsection (5), a person employed by or under contract to a hospital is eligible for the immunity and protection provided under subsection (3) only if the person meets all of the following conditions before reporting to the department the issue related to the hospital that is an unsafe practice or condition. . . .
>
> (a) The person gave the hospital 60 days' written notice of the issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or rule promulgated under this article. A person who provides a hospital written notice as provided under this subdivision shall not be discharged, threatened, or otherwise discriminated against by the hospital regarding that person's compensation or the terms, conditions, location, or privileges of that person's employment. Within 60 days after receiving a written notice of an issue related to the hospital that is an unsafe practice or condition, the hospital shall provide a written response to the person provided that written notice.
>
> (b) The person had no reasonable expectation that the hospital had taken or would take timely action to address the issue related to the hospital that is an unsafe practice or condition that is not a violation of this article or rule promulgated under this article.

MCL 333.20180(4).

100. Unless the statutory requisites of section 20180 of the Code are satisfied, the Nurses are not cloaked with immunity from civil or criminal liability granted under that section of the Code or the statutory protections from being discharged, threatened, or otherwise discriminated against by the Hospital as provided by the Code.

101. The Defendant's refusal to accept a nurse's written notice of an unsafe practice or condition is a violation of the Public Health Code.

102. The Defendant's refusal to respond to a nurse's written notice of an unsafe practice or condition is an unlawful repudiation of its statutory obligation to provide a written response to a person who submits a report of an unsafe practice or condition, in violation of Section 20180 of the Public Health Code.

103. The Defendant's refusal to accept and respond to a nurse's written notice of an unsafe practice or condition unlawfully impairs the ability of a nurse to qualify for the immunities and protections afforded by Section 20180 of the Public Health Code.

104. The Defendant's refusal to accept or respond to written notice from any of the Nurses of an issue related to the Hospital that is an unsafe practice or condition subjects the patients of the Defendant to unsafe conditions, inadequate medical care, and potential physical harm.

105. The Defendant's refusal to accept or respond to written notice from any of the Nurses of an issue related to the Hospital that is an unsafe practice or condition subjects the Nurses and other members of MNA who are similarly situated to unsafe work conditions.

106. A health facility, as defined in the Code, is required to post notices and use other appropriate means to inform persons employed by the health facility of their

protections and obligations under the whistleblower protection provision of the Code. MCL 333.20180(6).

107. The Defendant is a health facility as defined in the Code.

108. The Defendant does not post notices or use other means to inform persons employed by the Defendant, including the Nurses, of their protections and obligations under Section 20180 of the Code.

109. The Code grants LARA and the various health professional boards, including the Michigan Board of Nursing, the authority to license and to regulate health professionals. This authority includes the ability to take disciplinary action against licensed health care professionals based upon violations of a general duty, personal disqualifications, unethical business practices, unprofessional conduct, and other specific categories. MCL 333.16221.

110. Section 16221(a) of the Code authorizes discipline of healthcare professionals for "negligence or failure to exercise due care, . . . or any conduct, practice, or condition which impairs, or may impair, the ability to safely and skillfully practice the health profession."

111. The standard of care for all nurses is to ensure the safety of patients in their care.

112. Failure to deliver proper care to their assigned patients subjects the Nurses to potential disciplinary actions pursuant to the Code.

113. The Defendant's failure and refusal to comply with the requirements of the Code subjects the Nurses and other MNA members similarly situated to accusations that they are violating the standard of care for nursing, thereby placing said

Nurses and MNA members in jeopardy of disciplinary action.

RELIEF REQUESTED

WHEREFORE, Plaintiffs respectfully request that this Honorable Court:

A. Order an expedited hearing as required by MCL 15.240(5);

B. Enter a declaratory judgment against Defendant, providing that Defendant's failure and refusal to carry out its statutory responsibility to accept written notices of an issue related to the Hospital that is an unsafe practice or condition from the Plaintiff Nurses and other MNA members similarly situated is a violation of the Michigan Public Health Code; specifically, Section 20180 of the Code.

C. Enter a declaratory judgment against Defendant, providing that Defendant's failure and refusal to carry out its statutory responsibility to respond to written notices of an issue related to the Hospital that is an unsafe practice or condition from the Plaintiff Nurses and other MNA members similarly situated is a violation of the Michigan Public Health Code; specifically Section 20180 of the Code.

D. Enter a declaratory judgment against Defendant, providing that Defendant's failure and refusal to carry out its statutory responsibility to accept and respond to written notices of an issue related to the Hospital that is an unsafe practice or condition from the Plaintiff Nurses and other MNA members similarly situated results in the following:

(a) interferes with said nurses' rights and privileges provided by the Michigan Public Health Code; namely, immunity from civil and criminal liability and protection from being discharged, threatened, or otherwise discriminated against by the Defendant regarding their compensation or the terms, conditions, location, or privileges of their employment;

(b) subjects said nurses to accusations concerning their duty of care, thereby jeopardizing their professional nursing licenses; and

(c) subjects patients of the Defendant to unsafe conditions, inadequate medical care, and potential physical harm.

E. Issue an Order compelling Defendant to comply with the requirements of the Michigan Public Health Code; namely, to accept and respond to all written notices from nurses employed by Defendant who make a report or complaint of an issue related to the Defendant's health facilities that is an unsafe practice or condition.

F. Enter a declaratory judgment against Defendant, providing that Defendant's failure and refusal to carry out its statutory responsibility to post notices or use other means to inform persons employed by the Defendant, including the Nurses, of their protections and obligations under Section 20180 of the Code.

G. Issue an Order compelling Defendant to comply with the requirements of the Michigan Public Health Code; namely, to post notices or use other means to inform persons employed by the Defendant, including the Nurses, of their protections and obligations under Section 20180 of the Code.

H. Award such other legal and equitable relief deemed just and equitable, including but not limited to costs and attorney fees.

Respectfully submitted,

WHITE SCHNEIDER PC
Attorneys for Plaintiffs

By: _____
Shirlee M. Bobryk (P36919)

Dated: November 2, 2017