BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between	
DODGE COUNTY	Case 179 No. 49402 MA-7932
and	
DODGE COUNTY HEALTH FACILITY EMPLOYEES LOCAL 1576, AFSCME, AFL-CIO	

Appearances:
Mr. James L. Koch, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CI
Mr. Roger E. Walsh, Davis & Kuelthau, S.C., appearing on behalf of the County

ARBITRATION AWARD

According to the terms of the 1992-93 collective bargaining agreement between Dodge County (hereafter County) and Dodge County Health Facility Employees Local 1576, AFSCME, AFL-CIO (hereafter Union), the parties requested that the Wisconsin Employment Relations Commission appoint a member of its staff to act as impartial arbitrator of a dispute between them regarding a one-day suspension given to Margaret Bergen and a two-day suspension given to Barbara Haase for incidents which occurred on November 17, 1992. The hearing was held on September 28, 1992 at Juneau, Wisconsin, and a stenographic transcript of the proceedings was made. That transcript was received by the undersigned on October 15, 1992. The parties submitted their initial briefs by December 27, 1993 which were thereafter exchanged by the undersigned. The parties reserved their right to file reply briefs and the undersigned received a reply brief from the County on January 11, 1994 which was thereafter sent to the Union. The record was closed on January 17th when the Union advised it would not file a reply brief.

Issues:

The parties stipulated that the following issues should be determined in this case:

> Did the County violate the contract when it suspended Barb Haase for two days without pay and Margaret Bergen for one day without pay for the incidents that occurred on November 17, 1992?
>
> If so, what is the appropriate remedy?

Relevant Contract Provisions:

ARTICLE XVII
DISCIPLINARY PROCEDURE

> 17.1 The following disciplinary procedure is intended as a legitimate management device to inform Employees of work habits, etc. which are not consistent with the aims of the Employer's public function and thereby to correct those deficiencies:

A. For the first offense, the Employee may receive an oral written warning, not to be placed into any personal (sic) file.

B. For the second offense, the Employee may receive a written warning to be placed into the personnel file.

C. For the third offense, the Employee may be subject to disciplinary action.

D. For the fourth offense, the Employee may be subject to further disciplinary action, including discharge.

17.2 The above sequence of disciplinary action shall not apply in cases which Management feels are just cause for suspension or immediate discharge.

17.3 A disciplined Employee may appeal a demotion, suspension, discharge or written reprimand taken by the Employer beginning with the third step of the grievance procedure except that oral/written warnings shall begin with the first step of the grievance.

17.4 Notices to the Employees regarding this procedure shall be in writing with a copy provided to the Employee and the Union President.

17.5 **Community Health Center Employees:** Any disciplinary action sustained in the grievance procedure, or not contested, shall be considered a valid action. All documentation of such action will be removed from the Employee's personnel file at the end of a six (6) month period and will no longer be considered valid, with the exception of those actions relating to resident care. These shall be retained in the Employee's personnel file for a period of nine (9) months and will then no longer be considered valid.

. . .

Relevant County Policies:

RESIDENT BILL OF RIGHTS

The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. The facility shall protect and promote the rights of each resident, including each of the following rights:

EXERCISE OF RIGHTS:
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States, to be free of interference, coercion, discrimination, or reprisal from the facility in exercising his or her rights. All residents are encouraged and assisted, throughout their stay, to exercise their rights as residents and citizens. To assure that residents fully understand the nature and scope of these rights, any questions regarding these rights should be directed to a social worker of this facility. If, during a resident's stay, he or she becomes incapable of making his or her own health care decisions, the resident's designated person through a Power of Attorney for Health Care Decisions, or a guardian who has been appointed by the court, will be informed of, and may exercise, these rights on the resident's behalf. These rights are guaranteed under federal and state law, and are honored by the policies and staff of this nursing facility.

. . .

RESIDENT BEHAVIOR AND FACILITY PRACTICES

RESTRAINTS
The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

ABUSE
The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

STAFF TREATMENT OF RESIDENTS
This facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility will:

(1) Not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion;
(2) Not employ individuals who have been:
    (a) Found guilty of abusing, neglecting, or mistreating individuals by a court of law; or
    (b) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
(3) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

This facility shall ensure that all mistreatment, neglect, or abuse, including injuries of unknown

source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

This facility shall ensure that all alleged violations are thoroughly investigated, and shall prevent further potential abuse while the investigation is in process.

The results of all investigations shall be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

. . .

QUALITY OF LIFE

DIGNITY
This facility shall promote and care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

SELF-DETERMINATION AND PARTICIPATION
The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

. . .

DODGE COUNTY HEALTH FACILITIES

Policy and Procedure Regarding:

ABUSE OF RESIDENTS

. . .

POLICY

1. On the basis of these regulations, Dodge County Health Facilities further defines Resident abuse as including, but not limited to:

    1) Any single physical act causing any kind of Resident injury or unnecessary pain or discomfort.
    2) Any single physical act causing any kind of Resident fear, anxiety, or other mental anguish.
    3) Any single threatening gesture or other

mannerism causing any kind of Resident fear, anxiety, or other mental anguish.

4) Any single, threatening, demeaning, judgmental or similar verbal statement causing any kind of Resident fear, anxiety or other mental anguish.

5) Any tone of voice or loudness causing any kind of Resident fear, anxiety or mental anguish.

6) Any single act of neglect or deprivation which results in or could have resulted in any kind of Resident physical pain or injury or fear, anxiety or other mental anguish.

7) Any single act of taking resident's belongings without their permission.

2. Any abuse of any Resident of Dodge County Health Facilities by any Employee is totally incompatible with the philosophy, mission, goals and interests of our organization. Such abuse violates basic Resident rights and expectations, State law and regulations, and professional codes of conduct expected from long-term care personnel.

. . .

5. Dodge County Health Facilities recognizes that both the needs of individual Residents and the circumstances under which proper care must be provided can be very complex and extremely demanding on staff. Nevertheless, no form of abuse, however mild, unintentional or well-motivated will be tolerated.

6. <u>An Employee charged with abuse is considered innocent until proven guilty.</u> Any reported cases of abuse will be investigated according to existing policies and procedures, and if proven, will result in disciplinary action commensurate with the degree of seriousness of the offense, including suspension or discharge.

7. Any failure of any Employee to report any abuse of any Resident by any other Employee is similarly considered grounds for disciplinary action and similar penalties may apply.

8. Any harassment of any Employee or Resident who reports Resident abuse by any other Employee will likewise be considered grounds for disciplinary action.

9. It is the responsibility of Dodge County Health Facilities professional staff to develop treatment plans and approaches to meet the individual needs of residents.

10. It is the responsibility of all Employees

providing services to Residents to understand these treatment plans and approaches, to implement them accordingly, and, whenever in doubt as to the propriety of their actions, to consult with a Supervisor in advance.

Facts:

The two grievants, Barbara Haase and Margaret Bergen, are long-term employes of the County at its Health Care Facility. Haase has worked at the facility since 1966 as a program assistant (hereafter PA), while Bergen has been employed there as a PA since 1977. 1/ There was no evidence offered that either Haase or Bergen had ever previously been disciplined for any misconduct during their employment with the County.

On and before November 17, 1992, Haase and Bergen had regularly worked together as the only two PA's on the night shift stationed on Third Floor, A Wing (3A). The night shift is over at 6:30 a.m., although night shift employes are allowed to leave at 6:25 a.m. Seven morning shift PA's arrive at 6:00 a.m. each day for the start of their shift on 3A. At approximately 6:00 a.m. each day, a meeting is held wherein night shift PA's pass on necessary information regarding what occurred on the night shift to on-coming morning shift PA's. This meeting is known as "cross shift" and it is held at the nurse's station on 3A with the doors to that room closed and no residents present. Cross shift is not attended by the RN's or the Unit Coordinator, who arrive at work later than the PA's. Cross shift normally takes about ten minutes to complete. After cross shift, one night shift PA makes rounds on 3A while the other night shift PA makes rounds on a different wing, each with on-coming morning shift PA's present to check on all of the residents (who are normally still asleep at this time). Thereafter, each night shift PA must cross over to a different wing and get one resident out of bed, washed, dressed and ready for the day before they can leave their shift. Bergen stated, without contradiction, that the County frowns upon overtime incurred at the end of shifts to complete work which cannot be completed on shift. There is one night shift supervisor, Effie Madison, who floats all over the building during the night shift. During the day shift, there is an RN supervisor specifically assigned to 3A who is present on 3A during the day shift.

One of the residents who lives on 3A is PL, 2/ a developmentally disabled man with destructive tendencies. PL and another male resident are roommates at the facility, assigned to the same suite which includes a bedroom and bathroom. It is undisputed that PL frequently engages in destructive acts: stuffing items such as his bed linens, pillows, nightgown and clothing, into the toilet of the bathroom adjacent to his bedroom and then flushing the toilet, causing the toilet to overflow onto the bath and bedroom floors. 3/

1/ The PA position is the apparent equivalent of a nurse's aide position.

2/ The parties agreed to shield the identity of the resident involved herein by using only his initials, PL.

3/ All of the County witnesses, PA employes Bilke and Firari as well as RN Young, confirmed Haase and Bergen's statements regarding PL and his tendencies. Indeed, PL's program plan goal sheet states: "P. engages in property destruction on an average of < 1 per day. This includes flushing clothing down toilet, ripping materials, and smearing BM on curtains."

Because of PL's destructive tendencies, there are notations in the computer on 3A, in PL's program book and on his goal sheet, regarding procedures to follow after a destructive incident. These three procedures are inconsistent with each

other. The procedures quoted on PL's data collection sheet and found on the computer program covering PL, were effective in January, 1988 and were revised in September and October, 1990. These documents are kept in PL's records and on 3A and are also kept in the hallway book on residents.

The procedure on PL's computer program states:

> DESTRUCTIVENESS: TO MONITOR MEDS
>
> Problem: (Destructiveness is defined as any destruction to property,) e.g., ripping, flushing clothing, bedding, etc. This is being used to monitor meds. This is a low rate, everyday count, enter at hour of occurrence.
>
> (Proced: Intervention is by reinforcing him for shifts in which he has not been destructive. If caught destroying articles, redirect to another activity, & reinforce as soon as he is participating.) It is critical that he is clearly praised, even take him to room & point out how he has been appropriate. Reward with a cup of diet soda for completion of any/all shifts with no destructive behaviors, telling what soda is for.
>
> (Data:Count is for each occasion of destruction, entered at hour it occurs. All day every day count.)
>
> (CONTINUATION OF DESTRUCTIVENESS)
>
> (Problem: This is to be a continuation of procedure for program 6 for destructiveness: if property destruction occurs after bedtime, give one verbal cue to redirect back to bed. make sure he has all . . .)
>
> (Proced: Necessary bed linens and nightgown. After bedtime property destruction has occurred/check him every 15 minutes thereafter. This should be silently as only a visual check. Reward at the end of each shift that no property destruction occurred with a small cup of diet soda. Be sure to tell him why he is receiving the soda.) 4/

There is a different procedure, revised in June, 1992, listed on PL's goal sheet which is also found in PL's record and in the hallway book. It reads as follows:

> If property destruction occurs, verbally redirect P out of the area the destruction occurred. Do not

---

4/ The bracketed material above also appears on PL's data collection sheet.

> physically redirect him; repeat verbal redirects as often as needed. Involve him in the routine activities taking place on the unit.
>
> Verbally reinforce him as soon as he begins to participate in those activities. Point out how good it is that he is participating in the activity.
>
> If property destruction occurs after bedtime, verbally redirect P back to bed, and make sure he has all necessary bed linens and a nightgown.
>
> During the NOC shift check P every 15 minutes, regardless of whether or not property destruction has occurred. This should be done silently as only a visual check.
>
> Reward at the end of each shift that no property destruction occurred with a small cup of diet soda. Be sure to tell him why he is getting the soda.

All PA's have access to these documents for PL at the facility and they are responsible for knowing the contents thereof. If an incident of property destruction occurs, all of these procedures indicate that the PA involved must list the number of items damaged on PL's (weekly) data collection sheet before the end of their shift.

On November 17, 1992, PL either slammed his bathroom door or rang the call bell in his room at approximately 5:45 a.m. Margaret Bergen responded and found the bedroom floor flooded with water, PL sitting naked in his room on his bed springs with no mattress or bed linens in sight. PL's roommate was also in the room awake in his bed at this time. Bergen asked PL what had happened to his mattress and linen. PL said they were in the toilet. Bergen told PL to sit down and that what he had done was not right. Bergen then called Barb Haase to help her and the two of them moved the wet mattress, which PL had torn and jammed into the bathroom, out of the bathroom and into the dirty linen room down the hall. Haase and Bergen then removed the items from the toilet which PL put there before he flushed the toilet. 5/ They squeezed the water out of these items and placed them in the dirty linen room and they got mops and buckets to mop up the large amount of water that had by then, covered the floor of the bathroom and the bedroom and part of the common hallway outside PL's room. Both Haase and Bergen stated they could not recall another instance where PL had engaged in destructive activities just before the end of the night shift.

The RN supervisor was not present on 3A at the time of this incident. Haase stated on cross examination that she had called the RN supervisor after she and Bergen went into PL's room that morning, but Bergen could not recall that Haase had called the RN supervisor or that the supervisor had come to see

---

5/ There is some confusion regarding whether there was a nightgown in the toilet along with the sheets, blankets, pillowcase and pillow found there. Neither Bergen nor Haase could state with assurance that PL's nightgown was flushed but neither of them had put PL to bed that evening and, in any event, they stated, he was not wearing a gown (or any other clothing) when they entered his room on November 17th. I believe the evidence demonstrates that it is reasonable to conclude that PL sat naked on the vinyl chair from 6:05 to 6:45 a.m. on November 17th.

and consult on the problem with PL. Haase stated that she recalled that she called the RN supervisor that morning to ask for a machine to vacuum up water, and that the supervisor came to PL's room and saw him there naked when Haase and Bergen were still mopping up the water. The night RN supervisor did not testify at the instant hearing.

Neither Haase nor Bergen specifically recalled giving PL another gown before leaving his room to attend cross-shift. Haase recalled looking in PL's room for another gown to give PL after she arrived in PL's room on November 17th. 6/

Haase and Bergen were late getting to cross shift on November 17th. That day, cross shift was held in a closed room at the nurse's station after 6:05 a.m. Haase reported to the PA's who had come in for the day shift, the facts regarding PL having flushed items, torn his mattress, etc., and Haase admitted adding that if PL "sits on his bed springs and gets his jewels caught, you'll have to deal with it." 7/ Bergen said nothing during cross shift. Bergen then crossed over to the West Wing and went on rounds with day shift PA's there. Bergen thereafter assisted a resident on the West Wing to get out of bed and get dressed. Bergen never returned to 3A after she crossed over and she left work at 6:25 a.m. Bergen stated that she assumed that day shift PA's would attend to PL's needs after cross shift.

While Bergen was on the West Wing, Haase went on rounds on 3A with one or more day shift PA's (whose name(s) Haase could not recall). While on rounds (which began at about 6:15 a.m. that day), Haase went into PL's room with the

---

6/ Residents' day clothes are locked in their room closets while extra nightgowns are stored elsewhere. All PA's have keys to open these closets.

7/ None of the witnesses testified that Haase stated that PL was naked in his room and their written statements (of record) did not reflect that Haase made this statement. However, I believe that the evidence demonstrates that those who heard the "jewels" comment concluded from it and Haase's reference to the items PL had flushed in the toilet, that PL was then sitting naked in his room.

day shift PA or PA's. PL was sitting naked on the (vinyl) chair he had been sitting on while Bergen and Haase mopped up the water in his room. Haase admitted that neither she nor the day shift PA (PA's) gave PL another gown or his day clothes. They simply left PL there naked in his room.

After rounds, Haase crossed over to the West Wing to assist a resident to get out of bed and get dressed. She then left work at 6:25 a.m. It is undisputed that PA Virginia Grall had been assigned to care for PL on November 17th. Ms. Grall was not called as a witness herein and the County offered no explanation for Ms. Grall's failure to care for and dress PL after cross shift was over.

At 6:45 a.m. RN Young, who had had no prior contact that day with any PA's, went into PL's room on a routine AM medication pass and found PL naked, sitting on a vinyl chair with no mattress on his bed. Day shift PA Firari, who had been present at cross shift with Bergen and Haase and who had heard Haase's "jewels" comment, entered PL's room at about this time (just before 7:00 a.m.) She did this despite the fact that she was assigned to care for different residents on a different wing during the day shift. It took Young and Firari approximately 15 minutes to get a fresh mattress from a vacant room on another wing, to make up the bed and to give PL his clothes for the day. At 7:00 a.m., RN Young reported the incident regarding PL to her day shift RN supervisor. Young also reported this incident to Unit Coordinator Fellenz on November 17, 1992, sometime during the morning.

Later on, day shift PA's Firari and Bilke who had been present at cross shift when Haase made the comment about PL's "jewels," repeated and discussed this comment in the hallway of the facility. This conversation occurred a couple of hours after cross shift in an area where residents could have been present. RN Young overheard their conversation and reported this to Unit Coordinator Fellenz on November 17th when she reported the incident regarding PL.

Young's report triggered an investigation by Unit Coordinator Fellenz who requested statements from those involved. Fellenz did not personally interview any witnesses during her investigation but she received written statements from each witness. Thereafter, on November 19th, Fellenz contacted Facility Administrator Berry regarding the matter and submitted the evidence from her investigation to Berry and Gary Vanden Houten (Director of Social Services). On November 23, 1992, Fellenz also filed a complaint of abuse against Haase and Bergen in which Fellenz recommended Haase and Bergen be disciplined. Fellenz sent copies of this complaint to Vanden Houten and to Administrator Berry. However, in the interim before a decision could be made, Berry resigned to take another position and the disciplinary action against Haase and Bergen was forgotten for a time.

On February 2, 1993, after committee deliberations, and Haase's return from a long vacation in January, 1993, Bergen was issued a one-day suspension for (1) leaving ". . . resident P.L. sitting in his room naked, without a mattress or bed linens. . . ." On the same date, Haase was given a two-day suspension for (1) leaving ". . . resident P.L. sitting in his room naked without a gown, mattress or bed linens" and (2) for making the "jewels" comment at cross shift.

The Union timely filed a grievance protesting the discipline.

Additional Evidence Submitted by the County:

The County submitted evidence regarding prior discipline given to other employes in assertedly similar situations. One employe received a five-day suspension in 1992 following a resident's formal complaint that the resident was put on the toilet and left to clean herself with the bathroom light off and

the door slightly open. Another employe was suspended for one day in 1992 following a resident's formal complaint that the employe reprimanded the resident for not requesting toileting sooner and for reading the resident's dietary likes and dislikes in the dining room in front of other residents. In 1992, another employe received a one-day suspension for an incident in which the resident had scratched the employe whereupon the employe called the resident a "bitch" and stated, "I am going to call your father and tell him you pinched me. "In 1993, another employe was given a one-day suspension for yelling back at a resident, for ordering the resident back to her room (using the word "butt") and making "an additional degrading statement" in front of the resident and other staff members.

Positions of the Parties:

County

The County asserted that it had just cause to discipline Haase and Bergen for the incidents of November 17, 1992. It observed that it has policies and procedures which Haase and Bergen knowingly violated. The County cited the actions of Haase and Bergen on November 17th and urged that these actions violated County policies and procedures and violated PL's rights to privacy, dignity and respect. The County contended that Haase and Bergen's acts toward PL constituted neglect and abuse, and the County cited the opinions of its various witnesses to this effect. The County therefore asserted that the grievance must be dismissed.

Union:

The Union contended that the County failed to prove that the actions of Haase and Bergen on November 17th constituted "abuse" under Chapter HSS 129.03(a) or that they constituted "misconduct" pursuant to the Boynton Cab Company case (237 Wis. 249 (1941)). In this regard, the Union asserted that Haase and Bergen's actions were unintentional so as to amount , at most, to ordinary negligence. The Union urged that the County discriminated against and singled out Haase and Bergen for disparate treatment when there were seven other day shift PA's who knew of the situation, did nothing, and who should also have been disciplined for leaving PL naked in his room on November 17th. The Union also pointed out that the County waited two and one-half months before imposing discipline upon Haase and Bergen.

In the Union's view, the County had previously failed to give Haase and Bergen (or any other employes) instructions regarding how to handle an emergency such as the one that occurred here. In addition, the Union observed the County failed to demonstrate why a lesser (progressive) discipline should not have been

imposed. In regard to evidence submitted by the County regarding other cases of discipline, the Union contended that the County had failed to prove that these prior cases were relevant. The Union noted that the County also failed to submit any evidence of prior discipline of the Grievants to justify its failure to apply progressive discipline in this case. The Union urged that, therefore, the discipline meted out against the Grievants was punitive.

The Union argued that the "Seven Just Cause" tests of Arbitrator Dougherty should be applied in this case. On each of these tests, the Union urged that the County's evidence was insufficient to support the severe discipline given to the Grievants. In this regard, the Union noted that PL's treatment plan was entirely out of date on November 17, 1992. The Union asserted that the Grievants' judgment -- to mop up the water which constituted not only a safety hazard but also could have damaged the building -- was sound

at the time especially given PL's immediate willingness to sit down and be quiet during the mopping process. The Union further noted that it was reasonable for the Grievants to assume that Virginia Grall, who was assigned to care for PL that day, or one of the other six PA's on 3A that day, would complete the task of getting PL dressed and putting a mattress and linens back in his room. The Union observed that the Grievants were expected to complete other tasks before they left work on November 17th and that the County failed to prove that PL was in any way injured by sitting naked on the vinyl chair.

Therefore, based upon the record in this case, the Union sought an award sustaining the grievance, expunging the Grievants' records and making them whole.

Reply Brief:

The County timely filed a reply, a copy of which the undersigned sent to the Union on January 17th when the Union advised that it would not file a reply brief.

County:

The County argued that there was plenty of time for Haase and Bergen to clothe PL and put a mattress on his bed, contrary to the Union's contentions. The County claimed that although employes on the night shift are allowed to punch out at 6:25 a.m., they are expected to work until 6:30 if necessary. The County urged that the Grievants would have suffered no adverse consequences had they been a few minutes late for cross shift because they had to get a mattress for PL.

The County resisted the Union's contentions that day shift PA's were to blame for the fact that PL sat naked in his room without a mattress for an hour. The County urged that this does not change the fact that Haase and Bergen were the primary offenders. The County also discounted the Night Supervisor's alleged failure to act further upon viewing the situation in PL's room, noting that when she allegedly left PL's room, Haase and Bergen were acting appropriately -- mopping up the water.

The County urged that Haase's testimony was incredible regarding her having given PL a gown on November 17th when compared to documents she filled out at the time of the incident. The County also contended that PL's program plan (dated June 18, 1992) was up-to-date, contrary to the Union's assertions. The County asserted that it has not applied HSS 129.03(a) in this case to place Haase and Bergen on the abuse registry because the "abuse" was not serious enough to warrant such action. However, the County asserted, it was within its rights to discipline Haase and Bergen pursuant to Section 17.2 of the contract, which bypasses the need for progressive discipline.

The County observed that Firari and Bilke's conversation regarding Haase's comments about PL were different from Haase's original comments in tone and intent -- and that Haase was disciplined for the comments because her statement "was made in a derogatory manner, amounting to ridicule." The County explained that the two and one-half month delay in imposing discipline was unintentional and was due to the Administrator Berry's resignation and Haase's long vacation in January, 1993.

Finally, the County argued that "Haase and Bergen were guilty of improper conduct and the County had just cause for disciplining both of them." In this regard, the County further urged that the undersigned should be reluctant to alter the level of discipline meted out by the County, as the Union failed to

show that the County acted in an arbitrary, capricious or discriminatory manner toward the Grievants. In support of this contention the County cited several awards including this Arbitrator's award in City of Brookfield (Gallagher, 10/92).

Therefore, the County urged the undersigned to sustain the discipline and dismiss the grievance in its entirety.

Discussion:

At the time of the discipline herein the County had in place a Resident's "Bill of Rights" as well as a County policy relating to patient care and abuse. The former document indicates that residents have the right ". . . to be free of interference, coercion, discrimination, or reprisal . . .," it defines "abuse" as, inter alia, being free from "involuntary seclusions" and it states that facility employes should care for residents in a way that "maintains or enhances each resident's dignity. . . ." The County policy document defines "abuse" as inter alia ". . . 6) Any single act of neglect or deprivation which results in or could have resulted in any kind of Resident physical pain or injury or fear, anxiety or other mental anguish."

Both Haase and Bergen admitted being trained in and fully aware of these documents and policies. Thus, it is in this context that I must answer the initial question in this case -- whether the County had just cause to discipline

Haase and Bergen for their acts and omissions on November 17, 1992, regarding resident PL. Based on the relevant evidence submitted in this case, this question must be answered generally in the affirmative. 8/

The essential facts regarding Haase and Bergen's acts and omissions are not disputed. The bottom line is that on November 17th at approximately 6:05 a.m., Haase and Bergen left PL naked in his room with no mattress or linens on his bed in order to attend cross shift. The act of leaving PL in this state could have caused him "fear, anxiety or other mental anguish." Both Haase and Bergen must have known that PL would have to remain naked in his room with his roommate present from 6:05 a.m. at least until cross shift and rounds were over at about 6:15 a.m., when the PA assigned to PL (Virginia Grall) would be available to assist PL in getting ready for the day. Thus, no matter how pressed for time Haase and Bergen were on November 17th, good judgment and common sense should have told them to get clothes for PL before they left for cross shift, to maintain and enhance his dignity and to avoid his being involuntarily secluded. 9/ I note in this regard that both Haase and Bergen possessed keys to PL's clothes closet, that the evidence showed that PL was capable of dressing himself and that PL's goal sheet, program plans and data collection sheet each indicated that he should be given clothing after engaging in destructive behavior. 10/

But leaving PL naked in his room at 6:05 a.m. was not the sole conduct engaged in by Haase regarding PL on November 17th. It is significant that Haase had a second chance to give PL a gown or his clothes when she checked on him with the day shift PA (or PA's) during rounds after cross shift. Haase admitted that at this time she saw PL sitting naked on the vinyl chair. She also admitted, without giving any explanation for her conduct, that at this time, neither she nor the day shift PA (PA's) accompanying her gave PL his clothes or a gown. That Haase could leave PL naked in his room a second time evidences not just a mistake in judgment but a disregard for PL as a human being.

It is even more worrisome that the day shift PA (or PA's) who accompanied Haase on rounds must have shared Haase's disregard for PL because no one gave PL clothing to put on at this time. In addition, I am mindful that on this record, the County apparently entirely failed to discipline the PA (or PA's) who went on rounds with Haase on November 17th and who must have seen (and implicitly approved of) PL being left naked in his room at that time. The County also apparently completely neglected to discipline Virginia Grall, the PA who was assigned to care for PL on November 17th, whose failure to give PL proper care exacerbated the situation and resulted in PL sitting naked in his room for another 30 minutes after cross shift and rounds, until he was discovered by RN Young at 6:45 a.m. Clearly, from these November 17th incidents, there was a full field of candidates for discipline and additional

---

8/ As will be made clear later in this Award, the level of discipline meted out to the Grievant Haase was not proper. I also find that there were extenuating circumstances which adequately explained the County's failure to quickly pursue the discipline of Haase and Bergen.

9/ I find that neither Haase nor Bergen gave PL a gown or other clothing before they left his room for cross shift on November 17th.

10/ Both Haase and Bergen admitted being responsible to know the contents of these documents relating to PL's care. I also find that there was insufficient evidence to prove that the documents relating to PL's care were out-of-date, as the Union claimed.

training, yet the County chose to discipline only Bergen and Haase for the incidents of November 17th.

However, Haase's second omission to give PL clothing simply cannot be explained away or excused because other employes also failed to render PL the care he deserved to receive. I find that the County's decision to suspend Haase for one day for her failure to give PL clothing on November 17th was well-grounded and that that discipline should stand.

The County gave Haase a second day off without pay for referring to PL's "jewels" at cross shift. This action is not supported by the County's policies, by the Residents' Bill of Rights, or by past practice, and the County therefore failed to prove it had just cause to discipline Haase for this comment. In this regard, I note that nowhere in the County's policies or the Bill of Rights does it condemn comments made solely to staff in instances where residents are not present. Furthermore, the instances of prior discipline given to other employes for statements made, involved statements that were made to and/or in front of residents. Haase's comment was made only to employes behind closed doors so that the affect on residents was entirely absent.

Although the undersigned might not approve of such an indelicate statement, I am aware that such comments -- and worse -- may be made at work among employes. It is significant that no evidence was proffered regarding the kind of language normally used by employes at the County's facility. In addition, the County failed to prove that it had in place rules, policies and/or practices clearly prohibiting the type of language used by Haase while speaking to employes, that employes including Haase had been made aware of such rules/policies, and of the consequences of any infractions prior to any discipline being meted out. These principles of fundamental fairness were not followed in this case, and therefore the County's one-day suspension of Haase for Haase's "jewels" comment cannot stand. 11/

In contrast to Haase's conduct is Bergen's conduct. In my view, Bergen was guilty of a lack of good judgment on November 17th, not of any disregard for PL or his rights. I note specifically in this regard that because of her assigned work duties, Bergen had no contact with PL after she responded appropriately to the flooding emergency, 12/ that Bergen was assigned to other work that she was expected to complete on a different wing of the facility after cross shift and that she reasonably expected, after Haase's "jewels" comment at cross shift, that day shift PA, Virginia Grall, who was assigned to PL that day, would see to PL's needs.

11/ Again, I find it very worrisome that PA's Bilke and Firari were overheard in a public hallway where residents could have been present, to repeat Hasse's "jewels" comment and yet they were not disciplined or corrected by management in any way.

12/ It is too easy for the County to assert that there was plenty of time for Haase and Bergen to go to another room to get a new mattress for PL and fresh bed linens. The facts of record show that it took Young and Firari approximately 15 minutes to do these tasks. Haase and Bergen would have missed cross shift and rounds had they done these tasks and they would have thrown the day schedule off and incurred overtime which Bergen stated, without contradiction, was frowned upon by the County. In my view, it is unrealistic to hold Haase and Bergen responsible for failing to get a new mattress and linens for PL before attending cross shift, given the circumstances present on November 17th.

In these circumstances, the one-day suspension given to Bergen seems overly harsh. However, it is a generally accepted principle of labor arbitration that the level of discipline given by the employer should stand unless it is affirmatively shown that the employer acted in an arbitrary, capricious or discriminatory way or otherwise abused its discretion in setting the penalty. In this case, the Union failed to show that such an abuse of discretion occurred. Therefore, although the undersigned (had it been her decision) would not have given Bergen a one-day suspension for her acts and omissions of November 17th, the discipline given to Bergen by the County shall not be disturbed by this Award.

Based on the relevant evidence and argument herein, 13/ I issue the following

AWARD

The County did not violate the contract when it suspended Margaret Bergen for one day without pay for the incidents that occurred on November 17th, 1992. The grievance with regard to Bergen is therefore denied and dismissed in its entirety.

The County did not violate the contract when it suspended Barb Haase for one day without pay for the incidents that occurred on November 17, 1992.

However, the County lacked just cause for its suspension of Haase for one (additional) day for making the "jewels" comment. The County shall therefore expunge any reference to this one-day suspension from Haase's file and it shall make Haase whole for the one-day suspension she was given for the "jewels" comment. The grievance as to Haase is therefore denied in part and sustained in part.

Dated at Madison, Wisconsin this 3rd day of March, 1994.

By Sharon A. Gallagher /s/
Sharon A. Gallagher, Arbitrator

13/ The Union argued that Boynton Cab Co. v. Neubeck 237 Wis. 249 (1941), should be applied to this case. I disagree. Boynton involved an appeal of a decision by the Unemployment Compensation Commission in which the meaning of the term employe "misconduct," as used in Sec. 108.04(4)(a), Stats., was in issue. Nowhere in that case did it state that a collective bargaining agreement existed. In addition, it is clear under longstanding precedent that the standards used in determining whether a collective bargaining agreement has been violated and those used in U.C. hearings are separate and distinct. I find, therefore, that Boynton is inapposite to this case.