BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

GREEN COUNTY PLEASANT VIEW HOME EMPLOYEES, LOCAL 1162, WCCME, AFSCME, AFL-CIO

and

GREEN COUNTY

Case 143
No. 59008
MA-11148

(Schwartz and Wedig Discipline)

Appearances:

Mr. Thomas Larsen, Staff Representative, Wisconsin Council 40, AFSCME, 1734 Arrowhead Drive, Beloit, WI 53511, appearing on behalf of Local 1162.

Mr. William Morgan, Corporation Counsel, Green County, 1016 16th Avenue, Monroe, WI 53566, appearing on behalf of Green County.

ARBITRATION AWARD

Pursuant to the provisions of the collective bargaining agreement between the parties, Green County Pleasant View Home Employees, Local 1162, AFSCME (hereinafter referred to as the Union) and Green County (hereinafter referred to as the County) requested that the Wisconsin Employment Relations Commission designate a member of its staff to serve as arbitrator of a dispute regarding discipline imposed on two employees, Alice Wedig and Sherry Schwartz. The undersigned was so assigned. A hearing was held on September 14, 2000, at the Green County Courthouse in Monroe, Wisconsin, at which time the parties were afforded the full opportunity to present such testimony, exhibits, other evidence and arguments as were relevant to the dispute. No transcript was taken. The parties submitted post hearing briefs, and the County submitted a reply, which was received on October 23, 2000, whereupon the record was closed.

Now, having considered the testimony, exhibits, other evidence, contract language, arguments of the parties and the record as a whole, the undersigned makes the following Award.

To maximize the ability of the parties we serve to utilize the Internet and computer software to research decisions and arbitration awards issued by the Commission and its staff, footnote text is found in the body of this decision.

ISSUES

The parties agree that the issues before the Arbitrator are:

1. Did the County have good cause to discipline the Grievants?

2. If not, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

ARTICLE II
Management Rights

2.01 The Union recognizes the rights and responsibilities belonging solely to the County, prominent among, but by no means wholly inclusive are the right to hire, promote, discharge or discipline for cause. The right to decide the work to be done, and the location of the work. The Union also recognizes that the County retains all rights, powers or authority that it had prior to this Agreement except as modified by this Agreement. Reasonableness of management's decisions are subject to grievance procedure. However, the provisions of this Article shall not be used for the purpose of undermining the Union or discriminating against any of its members.

. . .

ARTICLE III
Conduct Of Business

. . .

3.09 The Union, as the exclusive representative of all the employees in the bargaining unit, will represent all employees, Union and non-Union, fairly and equally, and all employees in the Unit will be required to pay their proportionate share of the costs of collective bargaining and contract administration by the Union. No employee shall be required to join the Union, but membership in the Union shall be made available to

all employees who apply, consistent with the Union Constitution and By-Laws. No employee shall be denied Union membership because of race, creed, religion, color, sex, or age.

. . .

ARTICLE VII
Discharge and Suspension

7.01 The Employer may discharge any employee for good cause. An employee charged with an offense justifying immediate discharge, will be informed of such offense in writing at the time of his/her discharge, and a copy thereof shall be sent to the Union. All discharges shall be made in the presence of employee's Stewards, if possible. The Employer shall give at least one (1) warning notice in writing of a complaint for other offenses (those not involving immediate discharge) against such employee to the employee and the Union.

Discharge without a warning notice is authorized in cases of:

1. Dishonesty
2. Working under the influence of liquor or drugs
3. Willful destruction of property
4. Physical or verbal abuse of residents
5. Theft from employer or other employees or residents
6. Failure of an employee to report to work on three (3) consecutive scheduled shifts without any notification to the Employer, unless due to circumstances beyond the control of the employee.

. . .

7.06 CNA Registry. If a grievance is filed concerning an employee discharge which is subjected to registry review under state or federal law, arbitration of the grievance shall be held in abeyance pending a decision by the State. If the Employer suspends an employee during its investigation of conduct alleged to violate registry rules, the suspension will be with pay until the Employer makes its decision. The parties will be bound by the State's decision on whether the employee committed abuse. If the State finds that no abuse occurred, a discharged employee shall be reinstated with back pay.

7.07 Levels of Discipline. Discipline shall be administered on the principle that the discipline is to be corrective in nature, not punitive. Normally, discipline shall be given in the following steps:

1st step	oral warning
2nd step	written warning
3rd step	a second written warning or suspension (up to 7 days)
4th step	additional suspension or discharge

In exceptional cases, discipline may commence at the second or higher step depending on the severity of the offense committed.

A warning shall be considered null if the offense has not been repeated within twelve months. A suspension shall be considered null after twenty-four months if the offense complained of has not been repeated.

. . .

ARTICLE XXVI
Anti-Discrimination

26.01 Neither the Employer nor the Union shall discriminate in any manner whatsoever against any employee because of race, creed, religion, color, national origin, or sex. The Employer and the Union agree to comply in all respects with the provisions of the Age Discrimination in Employment Act of 1967.

BACKGROUND

The Employer provides general governmental services to the people of Green County, Wisconsin. Among these services is the operation of Pleasant View Home, a nursing facility for the elderly. The Union is the exclusive bargaining representative for the Home's non-professional staff, including Certified Nursing Assistants (CNA's). The Grievants, Sherrie Schwartz and Alice Wedig, are CNA's at Pleasant View, as is Mary Jane Reinbold. Robin Stein is the 1st Shift Nursing Coordinator and Pat Birkett is the Director of Nursing.

On Monday, February 28, 2000, an elderly resident, BWM, complained to Robin Stein about the treatment she had received the day before from Wedig and Schwartz. According to BWM, at about 10:30 a.m. on Sunday, Wedig and Schwartz assisted her to the bathroom. Because of severe ulceration on her heels, BWM needs help to stand, and often experiences pain when on her feet. The two CNA's did not use a gait belt to transfer her from her wheelchair to the toilet. When she was done, they began to transfer her back. Her knees buckled and she almost fell. Wedig told Schwartz "don't help her, let her struggle." When BMW complained about the terrible pain, Wedig told her to "quit your whining – you should reserve your strength to walk better." Wedig then sent Schwartz for a gait belt, but while she was gone, Wedig completed the transfer on her own.

According to BWM, when Schwartz returned to room, she and Wedig took her to the lunchroom. As they tried to place her in the lift chair, her legs froze up and Wedig berated her, telling her to sit back down in her wheelchair and they would just push her to the table. Wedig told her "it makes me sick that you don't help," accusing her of not trying to stand on her own. BWM told Stein she was so upset she just sat at the table crying until her lunch arrived, and then she was not able to eat it.

According to BWM, after lunch, when she wanted to go back to her room, Wedig and Schwartz were summoned to help her. Wedig made the comment that if she ever was assigned to BWM's room again, she would refuse. According to BWM, this hurt her feelings. She also reported that they made a rude comment about another resident's wife who was standing in the hall. Schwartz asked why the woman was standing in the hall and Wedig replied that she was standing there because she was nosey and wanted to hear what was going on.

Stein reported the allegations to Birkett. Birkett investigated the complaints by interviewing Wedig and Schwartz, as well as other staff members who were in the vicinity or had been told of the incident. Wedig said that during the morning transfer in the bathroom, BWM said it hurt when she was pivoting, and acknowledged not using a gait belt because none was at hand. She denied telling Schwartz to let BWM struggle or telling BWM to stop whining. According to Wedig, when they took BWM to the day room, another resident was sitting in her lift chair, and BWM said it was all right, and that she would just stay in the wheelchair. Wedig noted that BWM was complaining about pain the entire day. She acknowledged telling her to concentrate on using her energy to stand, but denied the allegation of any verbal abuse.

Schwartz told Birkett that BWM was carrying on about her pain all day. During the transfer in the bathroom, BWM was very apprehensive, but Schwartz said that was normal for her, and that she frequently said she was going to fall when she was in no danger of doing so. Wedig did tell her to concentrate on standing, but never told her to stop whining or shut her mouth. There was no gait belt available in the room, and Schwartz went to get one, but Wedig had completed the transfer by the time she got back. When they took BWM to the day room, another resident was in her lift chair. The other resident got out, but BWM said she was too tired to move from her wheelchair to the lift chair, so they left BWM in her wheelchair. Schwartz told Birkett she did not help put BWM back to bed after lunch, and did not know of anything being said to her at that time.

Birkett also spoke with CNA Mary Jane Reinbold, who said she had helped Wedig and Schwartz transfer BWM from her bed that morning, and that during the transfer when BWM complained, Wedig gestured to her lips and said "a little less of this and little more of this," gesturing to her feet. Social Worker Carole Knudson told Birkett that BWM had told her one of the CNA's had told her to stop whining and conserve her energy. RN Dorene Lee told Birkett that either Wedig or Schwartz had told her that they almost lost BWM during a transfer, when her legs buckled and she almost fell. Whichever one made the comments also

commented that BWM was not as cooperative with the transfers as she could be. Finally, Birkett spoke with the woman who was supposedly standing in the hall, and who had been referred to as nosey. That woman had no recollection of any remarks or incidents.

Based on this investigation, Birkett concluded that proper transfer procedures had not been followed, that there had been verbal abuse of a resident and that there had been a failure to report these violations. Nurse Lee was given a written reprimand for not reporting the improper transfer, and Reinbold was verbally reprimanded for not intervening to stop Wedig from verbally abusing the resident. Sherry Schwartz was given a written reprimand for not intervening to stop Wedig. The March 3rd disciplinary notice issued to her described the conduct leading to discipline as:

. . .

> Your involvement in the resident incident of 2/27/00 was not acceptable. Your failure to act as Resident Advocate, your failure to use a gait belt, and disrespect for Resident Rights warrants this written warning.

. . .

For her part, Wedig was given a three-day suspension. Her March 3rd disciplinary notice read:

. . .

> You are being suspended for 3 working days, Friday, 3/03/00, Saturday, 3/04/00, and Sunday 3/05/00 without pay due to the resident incident of 2/27/00. You displayed a disrespectful and lack of Residents Rights in caring for [BWM], a resident you were assigned to do cares.
>
> This type of care, disrespect will not be tolerated.
>
> On Tuesday, 3/07/00 when you return to work you will be inserviced on Resident Rights and the importance and use of gait belts before you return to patient care.

. . .

The incident was reported to the State of Wisconsin's Bureau of Quality Control, which conducted its own investigation and determined that there was insufficient evidence to indicate abuse. After that finding, the County Personnel Committee met to consider the grievances filed by Reinbold, Schwartz and Wedig. The Committee removed the verbal reprimand from Reinbold's file because she was not actively involved and did hear the entire abusive exchange.

It modified the discipline imposed on Schwartz, leaving the written reprimand in place, but directing that it be removed from her file after six months, rather than the usual one year. As for Wedig, the Committee reduced the suspension from three days to two, and remove it from her file after one year, rather than the usual two years. In modifying the penalties, the Committee was influenced by the good work histories of the employees, and the fact that all of them had undergone retraining.

Schwartz and Wedig continued to press their grievances and the matter was referred to arbitration. At the arbitration hearing, in addition to the facts recited above, the following testimony was taken:

Robin Stein testified that BWM was very upset and was crying when she reported this incident to her on February 28th. She acknowledged that the care plan called from BWM to be on her feet during transfers, that this was always quite painful for her because of the deep ulcerations in her heels, and that she always complained about it. The failure to use a gait belt during the transfer violated the care plan, and put her at risk of injury. Stein noted that BWM had a history of falls at the private care home where she had previously lived, and that this was a sign that greater care should be taken during transfers. Stein said that it was not common to ignore the use of a gait belt, but that it might happen if a staff member forgot that it was required by the care plan.

Stein acknowledged that, if BWM was upset and crying during the day on the 27th, it should have been charted in the nursing notes and that she did not know if the notes made any reference to this. Neither was she aware of anyone in the dining room or the day room who saw BWM crying or upset. Stein testified that the Patient's Bill of Rights gave residents the right to be treated with dignity and to be free of verbal abuse. She opined that a statement to the effect of "let her struggle" would be verbal abuse, as would be telling a patient to stop whining or shut up. Even the milder comment attributed to Wedig, "a little less of this and more of this" would be inappropriate, as it blames the patient.

Pat Birkett testified that, based on her interviews, she felt BWM had been told to "quit whining" or words to that effect, and that this violated her rights under the Patient's Bill of Rights. She also felt that the failure to use a gait belt was a clear violation of the care plan. She acknowledged that BWM's care plan had been changed right before this incident, from the use of a mechanical lift when transferring her, to having her pivot on her feet with assistance. This change was made by her physical therapist.

Alice Wedig testified that BWM had no problem in the morning with pivoting from her chair to the toilet, but did have trouble with returning to the chair. She recalled that BWM was complaining about being in pain all day, and that this was fairly common for her. When Schwartz went to get the gait belt, she completed the transfer by herself. She had no particular reason for doing this. Wedig did not recall any specific words she said to BWM, but felt that she had said nothing abusive.

Sherry Schwartz testified that she was regularly assigned to assist BWM. On the 27th, BWM was apologizing to them as they got her out of bed, which was normal for her. BWM was also upset because she was not able to pivot herself between her chair and the toilet, but did not want CNA's to help her. She had recently moved rooms, and the new room did not have the same frame around the toilet, which had allowed her to move from toilet to chair without assistance. During the transfer from the toilet to the chair, BWM was very upset, and Wedig tried to calm her down and get her to focus on the task at hand. She heard nothing abusive or inappropriate in Wedig's remarks, though she could not recall them word for word. Schwartz did not recall if BWM complained that her legs were buckling or locking up, though she did mention problems with the transfer later on when speaking to Dorene Lee.

Schwartz recalled that, after the transfer back to the wheelchair, she and Wedig took BWM to the day room for lunch. Another resident was in her normal chair, but she got up and they started to move BWM from her wheelchair. However, BWM said she was too tired, and they put her back in her wheelchair and pushed her over to the lunch table.

Schwartz acknowledged that BWM's care plan called for the use of a gait belt for transfers, but said gait belts were not always available and that transfers without a gait belt were quite common, although unauthorized.

Mary Jane Reinbold testified that she was not present for any incident in the bathroom, but had helped get BWM out of bed. During the transfer from her bed to the wheelchair, she was very nervous and complaining. Wedig told her "a little less of this and a little more of this," meaning she should focus less on talking and more on pivoting. Reinbold expressed the opinion that Wedig's only purpose was to get BWM focused on the task, and that there was nothing abusive or inappropriate about the comments she made.

Additional facts, as necessary, are set forth below.

The Position of the County

The County takes the position that the Grievants were disciplined for just cause and that the grievance should be denied. The Grievants were jointly assigned to care for an elderly resident. They transferred her from her wheelchair to the toilet and back again without using a gait belt, as required by the resident's care plan. On another occasion that same day, they transferred her from her bed to the wheelchair, also without using a gait belt. When the resident complained of pain, Grievant Wedig told her "a little less of this" (gesturing to the resident's mouth) "and a little more of this" (gesturing to the resident's feet). This failure to follow proper procedures and rudeness to the resident formed the basis of the discipline in this case. Both following procedure and showing courtesy and respect to residents are requirements of the Grievants' jobs, and failure to comply with these requirements provides just cause for discipline. Even if there were no written rules on this point, common sense

would tell a health care professional that care plans and the patient's bill of rights are not simply advisory documents. Here, an impartial and thorough investigation established that both employees failed to meet their responsibilities to this resident. They were treated fairly, and the discipline imposed was, on its face, reasonable in relation to the offense.

The County rejects any suggestion that there has been disparate treatment in this case. Grievant Wedig received the most severe discipline – a two-day suspension. However, she was the most culpable for the violations. It was Wedig who actually accomplished the transfers without using a gait belt, and it was Wedig who spoke rudely to the resident. While Wedig claims that her motives were good, her subjective intent is irrelevant. By any objective standard, she committed verbal patient abuse, and the resident who was on the receiving end was very upset by it. Schwartz was also disciplined, with a written warning, both because of her participation in the improper transfers and because she did not report them or the verbal abuse that she witnessed.

The County stresses that these are not trivial matters. Aside from the basic question of human dignity in speaking to the residents, the failure to follow proper procedures exposes the facility to severe sanctions by the State of Wisconsin and exposes residents to physical harm. Even though the State's investigation did not result in an indication of abuse, the State's determination of abuse is only binding in cases of termination. For lesser measures of discipline, as were meted out in this case, the County is entitled to rely on its own investigation.

The Grievants were guilty of serious violations of procedure and of failing to respect the rights of a resident. A thorough and fair investigation established their guilt, and the penalties imposed were reasonably related to the seriousness of the conduct. Thus, there is no basis for disturbing management's action, and the grievances should be denied.

The Position of the Union

The Union takes the position that the discipline of these two employees was not supported by cause, and should be overturned. The County accuses Grievant Wedig of resident abuse, and Grievant Schwartz of failing to report resident abuse. However, an independent investigation by the State of Wisconsin's Bureau of Quality Assurance found no abuse. The contract provides that the State's determination is binding in discharge cases, and by logical extension it should have great persuasive weight in cases involving other types of discipline. If there was no abuse, Wedig cannot be disciplined for abuse. If Wedig is not guilty of abuse, Schwartz cannot be disciplined for failing to report abuse. It necessarily follows that the County acted improperly in disciplining the Grievants. Thus, the Arbitrator should sustain the grievances and order that the reference to discipline be removed from the Grievants' files and that Wedig be made whole.

DISCUSSION

At the outset, I note that both the County and the Union rely on the same basic facts. Notwithstanding BWM's allegation that she was told to "shut up" or "quit whining" during the transfer from bed to the wheelchair, and that Wedig told Schwartz to "let her struggle" during the transfer in the bathroom, the County's brief accepts that the actual comments were "a little less of this and more of this" during the transfer from bed, and "concentrate on standing" during the transfer in the bathroom. The great weight of the record evidence indicates that these were, in fact, the remarks made. Additionally, the County does not recite or rely upon the alleged comments in the lunchroom. Again, the weight of the record evidence supports the County's posture, in that there is little evidence that any such remarks were made. From the record as it stands, the County concludes that Wedig committed verbal abuse of the resident, and that Schwartz failed to report verbal abuse. The County also cites the two for failing to use a gait belt for either transfer, even though the resident's care plan requires use of a gait belt.

A. The Gait Belt

The issue concerning the use of the gait belt is reasonably straightforward. The care plan calls for the use of a gait belt during transfers, and both Grievants knew this. They declined to use one because there was not one handy, but that is a choice that has no official sanction. It may be a common practice, but there is no evidence that management has acquiesced in that practice. Failure to follow a care plan is customarily a basis for both refresher training and discipline, with the measure of discipline depending upon what the failure was, and what harm resulted. Here, Reinbold, who was present during the transfer from bed to wheelchair, initially received a verbal reprimand, and then had the discipline expunged by the Personnel Committee. Even granting that the two Grievants were involved in two transfers, while Reinbold was involved in only one, it is difficult to believe that anything more than a verbal reprimand would have issued without the added element of disrespectful language and/or verbal abuse. Thus, the propriety of the written reprimand to Schwartz and the suspension of Wedig turns on whether Wedig's comments to BWM may fairly be characterized as abuse of a resident.

B. The Bureau of Quality Assurance

The State's Bureau of Quality Assurance judged that there was insufficient evidence to determine that Wedig's comments to BWM constituted abuse, and thus took no action on this case. The collective bargaining agreement specifically provides that in cases of discharge, the Bureau of Quality Control's determination is dispositive. The Union argues that the Arbitrator should defer to that agency's expertise in investigating cases of this type, and should accept their judgment that no abuse occurred. This position has some instinctive appeal, but it is not

sound as a matter of contract interpretation. The parties specifically bargained over the impact of a ruling by the State in abuse cases, and agreed that the Bureau's findings would be accepted by both of them in cases involving a discharge. Applying the familiar rule of contract construction that to express one thing is to exclude another, the necessary implication of the language limiting automatic acceptance of the Bureau's findings to discharge cases, and excepting those cases from arbitration, is that such findings are not conclusive in cases of lesser discipline. In cases of reprimand or suspension, the parties leave it to the normal grievance procedure to sort out the guilt or innocence of the employee. Thus, they have bargained for the judgment of the Arbitrator, not the State, in this case, and are entitled to a *de novo* determination of whether Grievant Wedig is guilty of abuse.

C. Verbal Abuse of a Resident

The contract provides that verbal abuse of a patient is grounds for immediate discipline. The County's "Resident Rights" policy provides, *inter alia*, that:

> The resident has a right to a dignified existence . . . . A facility must protect and promote the rights of each resident, including each of the following rights:
>
> . . .
>
> ABUSE
>
> The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment and involuntary seclusion.
>
> . . .
>
> QUALITY OF LIFE
>
> The resident has the right to receive courtesy and respect, and the right to dignity, self-determination and participation within an environment that promotes quality of life. . . .
>
> . . .

Employees are well-versed in the Residents' Bill of Rights, and know that they are obligated to abide by it. Apart from the specific document, employees can be held to know that they are not allowed to verbally abuse residents, simply as a matter common sense and common decency. Having said that, verbal abuse is not a self-defining term. What constitutes abuse can vary from setting to setting, depending upon the words said, the tone in which they are said, and the context in which they are said.

Wedig is alleged to have told the resident here to "concentrate on standing" during the transfer in the bathroom, and to have admonished her "a little less of this and a little more of this" during the transfer from her bed to the chair. The first of these comments is, on its face, completely innocuous. There is nothing abusive or disrespectful in telling a resident who is having difficulty in standing that she should focus on the task. If the comment was said sharply, in an irritated or even angry manner, it could be considered a form of verbal abuse. Many residents are wholly dependent upon their caregivers, and those caregivers are invested with greater power in the relationship than would be those who assist a less vulnerable population. However, there is little in the record to suggest that Wedig was speaking sharply or otherwise berating BWM during the transfer in the bathroom. It is a plausible explanation of why the resident was upset, but it is not the only plausible explanation or even the most plausible explanation. An honest evaluation of the record here does not allow me to draw any firm conclusions about the tone of the comment, and thus, I cannot find that it meets the standard for disrespectful or abusive language.

BWM's response to the statement that she should focus on standing rather than talking during the transfer from the bed to the chair – "a little less of this and a little more of this" – is somewhat easier to understand. By all accounts, the newly ordered pivot maneuver was very painful for her because of the ulceration of her heels. She was used to using a mechanical lift, and she was also frustrated by her inability to move about by herself. She could easily have taken this comment as a criticism, and clearly did take it as meaning she should "shut up." However, understanding how the resident could have taken umbrage at a comment is not the same thing as saying it is verbal abuse. Employees can be held to understand that an elderly population may be more sensitive and more prone to take things to heart than the population in general, but they cannot be held to a purely subjective standard of what constitutes abuse, based solely upon the reaction of a given resident. The difference between verbal abuse and a poor choice of words is slippery, and it cannot be articulated with any precision. However, one useful question to ask is whether an objective observer, familiar with the population, would find the comment abusive in content, tone or context.

Four people were present when Wedig made her comment to BWM – Wedig, BWM, Schwartz and Reinbold. BWM's reaction has already been discussed. Wedig, of course, testified that she said nothing abusive to BWM. She has an obvious motive to deny it, but that does not mean she is lying. Schwartz also testified that Wedig said nothing inappropriate or abusive to BWM, and Reinbold echoed this, saying she took Wedig's comment merely as encouragement for BWM to focus on the transfer. None of the three employees is a purely objective observer, since all of them received some measure of discipline out of this incident. However, Schwartz's discipline is relatively minor, and Reinbold's was expunged in the grievance procedure. I do not discount their impressions of what went on in BWM's room. Moreover, the arbitrator, who has no stake in the matter, cannot discern what it was about Wedig's comment that constituted abuse. The substance of the comment may have been less than perfect, but a reasonable person would not find it abusive. As with the first comment, tone is important, but there is nothing to suggest a harsh tone.

D. Summary and Conclusion

The Grievants' are plainly guilty of failing to follow the care plan for BWM, in that they twice transferred her on February 27th without using a gait belt. This is not a trivial matter, but neither is it the type of offense that would warrant more than the normal progression of discipline. The initial step in that progression is a verbal reprimand. On the far more serious question of verbal abuse, the fact that the State found insufficient evidence to establish abuse is not relevant to this dispute. The parties have agreed to use the State's determination in cases of discharge, but have left other types of discipline cases to the judgment of the Arbitrator. From the evidence adduced at hearing, it is clear that BWM was quite upset, and the Home had the right and the obligation to take her complaint seriously. Certainly, if the evidence showed that the aides said the words that she initially reported, including the lunchroom exchanges, there would be verbal abuse, and the County would be compelled to take action. However, the evidence does not establish that those words were said. What was said may have been taken ill by BWM, who was in pain and resentful of both the transfer procedure and her disabilities. An objective review of the substance of the comments does not show anything that is obviously abusive, and there is no evidence that Wedig's tone of voice would have conveyed an abusive intent. Without in any way questioning the good faith of the resident in complaining, or of the County in responding strongly, the evidence does not support the charge of verbal abuse. Neither, of course, can it support a charge of failing to intervene to prevent abuse. Accordingly, I conclude that the County had just cause to reprimand both Grievants for failure to follow the resident's care plan, but I also conclude that it lacked just cause for suspending Wedig or issuing a written reprimand to Schwartz.

On the basis of the foregoing, and the record as a whole, I have made the following

AWARD

1. The County had just cause to issue a verbal reprimand to both Alice Wedig and Sherry Schwartz for failing to use a gait belt to transfer resident BWM on February 27, 2000;

2. The County did not have just cause to issue a written warning to Sherry Schwartz for failing to intervene to prevent verbal abuse of a resident and/or failing to report verbal abuse of a resident;

3. The County did not have just cause to suspend Alice Wedig for two days for verbal abuse of a resident and/or disrespectful treatment of a resident;

4. The appropriate remedy is to remove all reference to the discipline, other than to a verbal reprimand to each employee for failing to use a gait belt, from

their personnel files; to limit the verbal reprimands to six months in the personnel files; 1/ and to make Wedig whole by repaying her for the two days' wages lost by reason of her suspension.

1/ The contract provides that disciplinary warnings are removed after 12 months if there is no repeat of the conduct. However, in the grievance procedure, the County's Personnel Committee limited Schwartz's written warning to six months. It would be a perverse result if, as a consequence of winning in arbitration, and being found not guilty of the more serious charges, she received a more durable warning in her file. Further, since the result of this arbitration is that Schwartz and Wedig have been found guilty of precisely the same conduct, and are therefore similarly situated, the penalties must parallel one another. Accordingly, the verbal reprimands are limited to six months duration from the original March 3, 2000 date of issuance, unless during that time, the misconduct had been repeated.

Dated at Racine, Wisconsin, this 31st day of January, 2001.

Daniel Nielsen /s/
Daniel Nielsen, Arbitrator

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