BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

SHEBOYGAN COUNTY

and

SHEBOYGAN COUNTY HEALTH CARE FACILITIES EMPLOYEES, LOCAL 2427, AFSCME, AFL-CIO

Case 343
No. 61738
MA-12050

(P.K. Grievance)

Appearances:

Ms. Helen M. Isferding, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 1207 Main Avenue, Sheboygan, WI 53083, on behalf of Local 2427 and the Grievant.

Attorney Michael J. Collard, Personnel Director, Sheboygan County, 508 New York Avenue, Sheboygan, WI 53081-4692, on behalf of the County.

ARBITRATION AWARD

According to the terms of the 1999-2001 labor agreement between Sheboygan County (County) and Sheboygan County Health Care Facilities Employees, Local 2427, AFSCME, AFL-CIO (Union), the parties requested that the Wisconsin Employment Relations Commission appoint an arbitrator to hear and resolve a dispute between them regarding the termination of Sunny Ridge Home employee P.K. The Commission appointed Sharon A. Gallagher to hear and resolve the dispute. Hearing was conducted at Sheboygan County, Wisconsin, on December 18, 2002. No stenographic transcript of the proceedings was made. The parties agreed to exchange their briefs directly with each other, a copy to the Arbitrator and to reserve the right to file reply briefs again directly with each other, a copy to the Arbitrator. All briefs in the matter were received by the Arbitrator by January 23, 2003.

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.

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ISSUES

The parties stipulated that the Arbitrator should decide the following issues:

Did Sheboygan County violate the collective bargaining agreement when it terminated P.K. from employment?

If so, what is the appropriate remedy?

RELEVANT CONTRACT PROVISION

ARTICLE 3

MANAGEMENT RIGHTS RESERVED

Unless otherwise herein provided, the management of the work and the direction of the working forces, including the right to hire, promote, transfer, demote or suspend, or otherwise discharge for proper cause, and the right to relieve employees from duty because of lack of work or other legitimate reason is vested exclusively in the Employer. If any action taken by the Employer is proven not to be justified, the employee shall receive all wages and benefits due to him/her for such period of time involved in the matter.

Sheboygan County shall have the sole right to contract for any work it chooses and to direct its employees to perform such work wherever located subject only to the restrictions imposed by this Agreement and the Wisconsin Statutes. But in the event the Employer desires to subcontract any work which will result in the layoff of any Health Care Facilities employees, said matter shall first be reviewed with the Union.

Unless otherwise herein provided, the Employer shall have the explicit right to determine the specific hours of employment and the length of work week and to make such changes in the details of employment of the various employees as it from time to time deems necessary for the effective operation of its Health Care Centers. The Union agrees at all times as far as it has within its powers to preserve and maintain the best care and all humanitarian consideration of the patients at said Health Care Centers and otherwise further the public interests of Sheboygan County.

In keeping with the above, the Employer may adopt reasonable rules and amend the same from time to time, and the Employer and the Union will cooperate in the enforcement thereof.

RELEVANT PROVISIONS OF THE PERSONNEL HANDBOOK

XVIII. PROGRESSIVE DISCIPLINE

A. POLICY

Sheboygan County shall conduct discipline in a corrective manner. Reasonable efforts shall be made to correct problems before utilizing the disciplinary process outlined in this section. If it becomes necessary to discharge a person, our corrective approach has failed. The process, however, shall not be used to create an atmosphere of fear, and threats to invoke any aspect of the procedure shall not be made in the absence of a specific problem.

B. PROCEDURE

When it is necessary, discipline will be conducted by the employee's immediate Supervisor through one of the following types of discipline:

1. Verbal Warning

If a verbal warning is given, a record of this reprimand should be made clearly stating the date and the reason for the reprimand. A corrective approach should be emphasized with the employee. Use the Sheboygan County Employee Report Form.

2. Written Warning

If a written warning is given to the employee, it shall contain:

a. The reason for the corrective action.
b. The corrective action to be imposed.
c. The effective date and the length of the corrective action.
d. The results of failure to correct the problem.

A corrective approach should be emphasized

3. Suspension:

If a letter of suspension is warranted, the letter should include:

a. The reason for the corrective action.
b. The corrective action to be imposed.
c. The effective date and length of the corrective action.
d. The results of failure to correct the problem.

4. Discharge

If, in the judgement of the Supervisor, discharge is warranted, a letter of discharge should be issued listing:

a. The reason for the discharge.
b. The effective date.

C. IMPLEMENTATION

Decision-making:

In making the decision to implement corrective action within the policy of employee progressive discipline, it should be remembered that the underlying philosophy is that discipline, to be meaningful, must be corrective, not punitive; to be fair, discipline must treat employees similarly situated in a similar manner; and to be just, the action must be factually grounded. The threshold questions justifying the action ordinarily are:

a. Did the employee actually participate in the improper action?
b. Did the employee's act or misconduct warrant corrective action?
c. Is the contemplated corrective action appropriate to the circumstances?

To the end that equality of treatment can be achieved, it is suggested that management persons involved in the corrective discipline process, from time to time, consult with the Administrator as to action taken or contemplated. The ultimate determination as to the course of action lies with the Administrator, and the involved Administrator has the responsibility for making these personnel decisions and is responsible for the actions that result therefrom. Standard report forms recording disciplinary actions shall be completed timely and filed in the Personnel Office.

Examples of Work Rule Infractions:

An employee may be disciplined for, but not limited to, the following infractions of work rules:

a) Consumption of alcoholic beverages during scheduled work period.
b) Use, possession, or sale of illegal drugs on County premises or during working hours.
c) Theft of County property.
d) Carrying a weapon on County premises, except law enforcement personnel.
e) Absence of three (3) consecutive days without leave.
f) Breach of statutory confidential materials.

g) Non-compliance with County Ordinances or written departmental rules or procedures.
h) Being disrespectful to clients or to the public.
i) Creating a disturbance on work premises by fighting or other conduct, which adversely affects morale, production or maintenance of proper discipline.
j) Sleeping on duty.
k) Illegal gambling during working hours or on County property.
l) Violation of safety rules.
m) Performing personal work during working hours or on County property.
n) Falsifying or refusing to give testimony when job related accidents are being investigated.
o) Willful misuse, abuse or damage to property.
p) Harassment of fellow employees.
q) Falsifying reports or records
r) Reporting to work under the influence of drugs or alcohol.
s) Abuse of coffee or lunch break time limitations,
t) Poor work performance
u) Absenteeism
v) Tardiness
w) Falsifying time cards
x) Insubordination, including refusal to perform the work assignment.
y) Misuse of sick leave.
z) Patient abuse.

The above does not constitute a complete list of potential infractions of work rules.

Discipline Recommended:

For consistency by administering discipline Countywide, the following discipline standard should be considered for violation of the above examples.

The following recommended sequence of steps may be altered by the Administrator depending upon the severity of the infraction.

Examples of Improper Conduct	**Level of Discipline in Usual Case Without Aggravating or Mitigating Circumstances**				
	Number of Offense(s)				
	1st	**2nd**	**3rd**	**4th**	**5th**
Non-compliance with any law or regulation regarding Long Term Care compliance not otherwise addressed within	verbal reprimand	written reprimand	1 day off without pay	5 days off without pay	discharge
Illegal gambling during working hours or on County property	verbal reprimand	written reprimand	1 day off without pay	5 days off without pay	discharge

Falsifying or refusing to give testimony when job related accidents are being investigated.	verbal reprimand	written reprimand	1 day off without pay	5 days off without pay	discharge
Abuse of coffee or lunch break time limitations	verbal reprimand	written reprimand	1 day off without pay	5 days off without pay	discharge
Poor Work Performance	verbal reprimand	written reprimand	1 day off without pay	5 days off without pay	discharge
Absenteeism	verbal reprimand	written reprimand	1 day off without pay	5 days off without pay	discharge

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Failure to provide care and service in accordance with standards of practice, facility policy and/or regulatory compliance	written reprimand	1 day off without pay	5 days off without pay	discharge	

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Falsifying reports or records	discharge				

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Failure to report a violation of policy, law, regulation, Code of Conduct or regularity practice	discipline may be in varying degrees according to the severity
Failure to comply with a federal OBRA regulation and/or state regulation	discipline may be in varying degrees according to the severity
Breach of business, work product, or confidential material	discipline may be in varying degrees according to the severity
Failure to report resident abuse, neglect, or misappropriation or resident property	discipline may be in varying degrees according to the severity
Retaliation or reprisal against any employee who reports a violation of the Code of Conduct	discipline may be in varying degrees according to the severity
Undisclosed conflict of interest	discipline may be in varying degrees according to the severity
Violation of safety rules	discipline may be in varying degrees according to the severity

Performing personal work during regularly scheduled work period	discipline may be in varying degrees according to the severity
Insubordination including refusal to perform the work assignment and/or leaving the workplace without authorization	discipline may be in varying degrees according to the severity

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Wandering & Elopement Policy:

In January, 2001, the Sunny Ridge Home issued the following policy regarding Wondering & Elopement, which was later revised in May, 2002:

. . .

Policy: All staff are responsible for redirecting residents who have a potential to be unsafe in the community unattended, from leaving the facility and for assisting in the search for a missing resident. Elopement will be identified by: leaving the property known as Sunny Ridge located at 3014 Erie Ave., Sheboygan, Wl 53081

Propose: To protect the safety of residents who are at high risk for elopement.

I. Equipment:
   A. Alarmed door system activated at all times indicated.
   B. Wanderguard bracelets applied to residents who have a potential to be unsafe in the community, unattended.
   C. Photograph binder: each resident photo fitting this criterion located on each unit, to each department head and at the reception desk.

II. Procedure:
   A. Upon admission, the Admission Director and unit supervisor will complete the "Risk for Wandering and Elopement Assessment" (see attached) to determine whether the resident is at risk for elopement.
   B. If a person is identified as at high risk for elopement, the following shall be implemented:

. . .

2. Post Admission:
    a. If a resident begins to exhibit potential risk for elopement, the interdisciplinary team will evaluate the need for Wanderguard placement.
    b. A Wanderguard bracelet will be applied to resident by Nursing.

    c. A photograph will be obtained by Nursing immediately and be placed in the binders on each unit and at the reception desk.
    d. Nursing will program on treatment sheet to check for placement on each shift and to check for functioning every 24 hours.
    e. All departments will be notified of the resident change.

3. Maintenance of Elopement Binder:
    a. Receptionist will check census sheets daily and remove pictures of deceased/discharged residents or those determined no longer at risk.
    b. Receptionist will update listing and distribute to all departments monthly.

III. Monitoring:

A. Bracelets
1. Nursing will check placement of bracelet each shift and document on the treatment sheet.
2. Missing bracelets will be replaced immediately through the Nursing Supervisor on duty.

B. System
1. The Director of Building Services, or designee, will check operation of the main system weekly and record on flow sheet. Flow sheets will be maintained with the Director of Building Services.
2. If the system is not operational the Director of Building Services will notify the Nursing Home Administrator and Director of Nursing immediately and take the necessary steps to correct the malfunction.
3. An employee will be assigned to monitor the malfunctioning exit until service is restored.

. . .

H. After the resident has been returned, the Nursing Supervisor will:

1. Document the incident in the medical record.
2. Complete incident report.
3. Notify all previously contacted persons of the resident's return.
4. Assess the resident and report any unusual findings to the physician

for further interventions.

5. Initiate and update problem on the care plan.
6. Institute 15-minute checks on the resident or assign 1:1 supervision as needed.
7. Notify Social Services if resident continues to peruse [sic] elopement after return to facility.

8. Place resident on 24-hour report for follow-up.

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The above-quoted policy was kept at the nurses station for reference by all staff.

BACKGROUND

Sunny Ridge Nursing Home is located in Sheboygan, Wisconsin. Sunny Ridge has a North Unit which is six floors, including therapy and storage, and a South Unit which comprises three floors. There are 31 residents on the North Unit on each of the first through fourth floors; there are 14 residents on 5 North, and 6 North is the therapy and storage area for the facility (no residents live on that unit). 3 North and 4 North are maintained for Alzheimer's patients. The South Unit has three floors where residents live.

The Grievant, P.K., 1/ was employed at the Sunny Ridge Home as a Certified Nursing Assistant (CNA) from February 12, 2001, until her discharge on July 22, 2002. On November 14, 2001, P.K. received a one-day suspension without pay for an incident which occurred on November 11, 2001. The reason for her suspension was that she violated rules found at pages 40 and 42 of the Personnel Handbook, "Failure to provide care and service in accordance with standards of practice, facility policy and/or regulatory compliance" and "violation of safety rules" by her failure to follow the care card for a specific patient to whom she was assigned, by putting up side rails on the patient's bed when this was not called for. 2/

1/ The Grievant's initials will be used in this Award.

2/ According to the record in this case, this one-day suspension has been grieved and that grievance was still pending settlement or hearing on the date of hearing in the instant case.

On March 28, 2002, P.K. was issued a five-day suspension for a second "violation of safety rules" for care she gave a specific patient on March 22, 2002. On that evening, P.K. failed to put the personal magnetic alarm (PMA) on a resident before putting the resident to bed, although the care card for this resident stated that a PMA should be in place along with a motion sensor before the resident is put to bed. The County found this was a safety violation,

and because P.K. had been given a one-day suspension in November, 2001, the County gave P.K. the next step, a five-day suspension for this safety violation. 3/

3/ P.K. did not grieve this five-day suspension.

All witnesses who testified herein stated that the purpose for a 30-minute checklist on a resident at risk for elopement or suicide is to check at or close to the times listed on the checklist, where the resident is and whether the resident is well. In addition, all witnesses who testified herein on the point stated that the purpose of the checklist would be lost or the action of checking the patient would be meaningless if the employee assigned to check the patient every 30-minutes filled out the form in advance of the times listed. In addition, however, it was undisputed that employees at Sunny Ridge are very busy during their shifts and that it is difficult for them to check each patient that has a 30-minute checklist precisely at the time indicated.

Charge Nurse Mary Kohlbeck who was in charge of the facility on July 19, stated herein that 30-minute checklists are legal documents which must be maintained in each patients' medical chart, where applicable, and these checklists are important to be filled out accurately and at approximately the time (each 30 minutes) pre-printed on the checklist. Kohlbeck stated that it is never acceptable to fill out a 30-minute checklist in advance of the check times listed as if the employee had checked the patient at the time. Kohlbeck stated that in order to correct an error on a checklist, employees should cross out the incorrect notation, initial it and put in the correct information.

Employee Scott Doro stated herein that prior to July 19th, night shift employees including himself had filled out 30-minute checklists for patients for an entire shift in advance; that if the information was not correct at the end of his shift, Doro stated that he went back and lined through the information and corrected it. Doro also stated that employees at the Home check residents on 30-minute checklists approximately every 30 minutes or someone else on the unit may perform the check for them and tell the assigned employee that the resident was checked, was present and well. Doro stated that this is necessary due to the press of duties at the Home for CNA's. Doro stated that he normally does his charting at the end of the shift. Doro stated that resident K.Z. 4/ had regular patterns of activity making his whereabouts predicable.

4/ The resident's initials are being used herein to protect the resident's privacy.

Former employee Sara Woods 5/ stated herein that she filled out 30-minute checklists at the beginning of the shift or after the shift was over prior to July 19th. Both Woods and P.K.

stated herein that no one from management told them that it was acceptable to fill out 30-minute checklists ahead of time.

5/ Woods was fired by the County prior to the instant hearing on unrelated charges.

FACTS

On July 19, 2002, P.K. was responsible for 8 of the 31 Alzheimer's residents on 3N and to fill out a 30-minute elopement checklist on resident K.Z. P.K. admitted that at some point during her 2:30 to 11:00 p.m. shift on July 19th, she filled out the checklist for K.Z. ahead of the times printed thereon, such that she made five entries from 8:30 through 10:30 and initialed these, indicating that she had checked K.Z. and that he was either in the corridor or in his room during this time. There is some dispute regarding exactly when the following events occurred. However, based upon the evidence herein, the Arbitrator finds that the following events occurred on July 19, 2002.

Just before 8:00 p.m., K.Z. had returned with Sara Woods from having smoked a cigarette outside the building and was seated in a recliner near the nursing station, having a snack before bedtime. At this time, P.K. was at the nursing station doing paperwork and saw K.Z. in the recliner eating and recorded his whereabouts correctly for 8:00 p.m. CNA Emily (who was scheduled to work from 2:30 to 8:00 p.m. that day) had gone off the floor at this point and Sara Woods was taking trays and/or dirty linens downstairs. Lori Mulloy, the Nurse on 3N that evening, was passing pills at this time. At this time, CNAs Rochelle and Christine went on their breaks, leaving P.K. as the only employee on 3N except for Nurse Lori Mulloy. On July 19, Woods and CNA Rochelle were scheduled to have their breaks at 8:15 p.m. while P.K. and LPN Christine were scheduled to have their breaks at 8:45 p.m. Apparently, the schedule was not followed on July 19th.

At approximately 8:20 p.m., Charge Nurse Kohlbeck received a call from an off-duty employee who stated she had seen resident K.Z. walking east on Kohler Memorial Drive, approximately 8 blocks from the Home. Kohlbeck then called Nurse Mulloy to inquire whether K.Z. was present on 3 North. Mulloy searched and told Kohlbeck that K.Z. was not present on 3N. Kohlbeck then requested that two staff members be sent out to look for K.Z. Mulloy selected Sara Woods and P.K. to search for K.Z. Shortly thereafter, employee Mike Skelton offered to take his car and look for K.Z. Kohlbeck agreed.

Kohlbeck then called Director of Nursing Sherry Whitty and informed her of the situation. This was at approximately 8:30 p.m. Skelton returned to the facility between 8:30 and 8:40 p.m. and told Kohlbeck that K.Z. had been found at Business Drive and Michigan Street, approximately 15 blocks from the Home; that K.Z. had refused to get into Skelton's car, but he agreed to walk back to the facility with Woods and P.K. Kohlbeck then called Whitty to update her on the situation. This was between 8:40 and 8:45 p.m.

At some point prior to 9:00 p.m. when P.K. and Woods returned with K.Z., Kohlbeck discovered that P.K. had filled out and initialed K.Z.'s 30-minute checklist in advance of the times printed thereon. Kohlbeck made a copy of the sheet as it appeared prior to 9:00 p.m. in K.Z.'s chart showing that P.K. had checked K.Z. at the printed 30-minute intervals from 8:30 p.m. through 10:30 p.m. and that P.K. had initialed each check and listed K.Z.'s whereabouts as in the corridor or in his room.

At approximately 9:00 p.m., P.K. and Woods returned to the facility with K.Z. K.Z. could not recall which door he had exited the building, but his code alert bracelet (Wanderguard) sounded the alarm when tested that evening. 6/ No one present who testified herein recalled hearing an alarm go off that evening prior to K.Z.'s return.

6/ The kitchen door on the Sunny Ridge Home has no alarm. The front door has the code alert alarm, which the Wanderguards of residents should set off. Other doors at Sunny Ridge have alarms on them which can be disabled. Sara Woods stated that the front door alarm did not go off when she and P.K. returned with K.Z. However, I find Mary Kohlbeck credible and her version on this point has been credited.

Kohlbeck then had each CNA/LPN as well as Nurse Mulloy and the Grievant, write statements separately regarding what had occurred that evening. Kohlbeck stated herein that she had no knowledge that employees at the Home were filling out 30-minute checklists in advance of the times printed thereon and that if this was occurring it would never be acceptable. Director of Nursing Sherry Whitty stated that staff are trained regularly to keep charts accurately and in a timely fashion in in-services, orientations and nursing meetings.

After Kohlbeck had collected statements from everyone on duty after 8:00 p.m. on July 19, 7/ she decided to in-service the employees regarding the proper manner in which to fill out 30-minute checklists and the importance thereof. Kohlbeck stated herein she did this because she felt it was good nursing practice, not because employees were unaware how they should fill out the form. Some time during the evening, Kohlbeck and P.K. had a conversation in which P.K. stated that she wasn't sure why she had filled out the 30-minute checklist for K.Z. in advance, that this was not something that she would normally do, but that she was just doing her paperwork and she decided to complete the form in advance through 10:30 p.m. 8/ Sara Woods requested that she and P.K. be allowed to change K.Z.'s 30-minute checklist to reflect what had in fact occurred and that Woods be allowed to co-initial with P.K. on the checklist. Kohlbeck agreed but retained the copy she had made of the original checklist.

7/ CNA Emily left the facility at approximately 8:00 p.m. and was not asked to give a statement.

8/ P.K. specifically denied making this statement to Kohlbeck. I have found Kohlbeck to be credible herein and I credit her version of this conversation. I note that P.K. admitted that on July 19th she

stated she was worried that she might be fired because of the situation that occurred on July 19th and that she had discussed her employment status with Kohlbeck, who indicated to her that she (Kohlbeck) had no idea of what would happen concerning P.K.'s employment.

P.K. worked on Saturday, July 20th; she was off on Sunday but worked on Monday, July 22nd, on which day the County notified her that she was terminated. 9/

9/ Contrary to the Union's assertions, I do not find it remarkable that P.K. was allowed to work on July 20th while the County completed its investigation.

Director of Nursing Whitty indicated that the County considered the prior suspensions that P.K. had served in November, 2001 and March, 2002 in deciding to terminate P.K. for falsifying records and a safety violation, pursuant to the County Personnel Handbook. On July 22, 2002, the County therefore issued P.K. the following termination notice 10/:

. . .

STATEMENT OF INCIDENT

On 7/19/02 P. falsified records by completing the every 30-min. check sheet for a resident at known risk for elopement ahead of time. When the unit nurse checked the record, she notified the charge nurse. The charge nurse made a copy of the resident's 30-min. check sheet at approx. 2020. P. initialed and determined where the resident was through the end of the shift (2230). P. had documented that at 2000 the resident was "off unit supervised" and at 2030 he was "in the corridor". In fact the resident was noted to be out of the building (elopement and in an unsafe environment) from approx. 2000 to 2100. Therefore, he could not have been where she indicated he was at 2000 & 2030. Furthermore, P. could not have known where the resident was going to be at 2030, 2100, 2130, 2200, & 2230. P. had documented, prior to charge nurse photocopying the record, on the resident's record he was "in the corridor" at 2100 & 2130 and he was "In room" at 2200 & 2230. This is considered Falsification of Records. According to the Sheboygan County Personnel Handbook, page 40, falsifying reports or records is considered grounds for discharge. At this time P. will be discharged from employment at Sunny Ridge.

In addition, P. did not know the whereabouts of a resident, at known risk for elopement, charged to her care. Based on above information, resident was in an

unsupervised, unsafe environment. This would be considered a safety violation. P. received a 5-day suspension for a safety violation on 3/28/02. According to the Sheboygan County Personnel Handbook, page 42, also based on past practices of safety violation disciplines, this would be grounds for discharge as well.

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10/ The name of the Grievant has been removed from the document quoted above.

P.K. stated herein that she checked resident K.Z. every 30 minutes except during his elopement on July 19th from the Home. P.K. stated that she had filled out the checklist the way other CNA's did it during the eight months that she was at Sunny Ridge, by filling in her initials and a number for K.Z.'s whereabouts in advance of the times printed on the form. P.K. stated that on July 19th after she returned with K.Z., Kohlbeck told her that she had been charting wrong and that she must put her initials on the checklist and fill it in at the times listed. P.K. was the first employee to be terminated by the County for failing to fill out a 30-minute checklist properly.

The County put into the record 30-minute checklists for resident K.Z. which covered the period April 14, 2002, through July 18, 2002 (County Exh. 10). Although there was a good deal of argument regarding the value of these checklists, on cross-examination P.K. found only one document, April 26, 2002, whereon she had changed the whereabouts numbers for resident K.Z. without lining through them and initialing them. In addition, Union representative Scott Doro found that he had been assigned to check K.Z. on April 17, 21, 24 and 28, yet he had made no corrections on these documents, as he asserted was his practice in his testimony in this case.

POSITIONS OF THE PARTIES

The County

The County urged that P.K. falsified an important document, part of a resident's medical chart, which the State requires to be kept and which must be relied upon by medical professionals. The County noted that P.K. admitted filling out the elopement checklist ahead of the times listed thereon. Therefore, P.K.'s entries for the time period between 8:00 p.m. and 10:30 p.m. were false.

In response to the charge against her, P.K. has relied on the "everybody's doing it" defense. However, the County asserted that it never knowingly allowed violations of its rules to go unpunished. Indeed, the County argued that the Union failed to prove that employees

regularly falsified elopement checklists and the Union failed to prove that management knew that employees were falsely reporting the whereabouts of patients on these lists and that management condoned it.

In this regard, the County noted that Union official Doro stated that he filled out elopement checklists for the night at one time; that at the end of the night, if any entry turned out to be incorrect, Doro would line through it, write "error" and put in the correct

information. However, the County noted that the documents contained in County Exhibit 10 contradict Doro's testimony, showing that Doro did not follow his own description of his normal practice over the three-month period covered by County Exhibit 10. Furthermore, although P.K. stated that she filled out the entire checklist for the shift ahead of the times printed thereon on a regular basis and that she would make changes at the end of her shift if the numbers she had listed for K.Z.'s whereabouts in the Home were incorrect, her testimony was not supported by the evidence. In this regard, the County noted that County Exhibit 10 showed that on only one evening did P.K. write over entries that she had made on a checklist for K.Z.

The County argued that the testimony of Nurse Mary Kohlbeck should be credited over that of P.K. In this regard, Kohlbeck clearly stated that P.K. admitted on the evening of K.Z.'s elopement that she did not normally prepare checklists in advance and she did not know why she had done so on July 19th. As Kohlbeck had nothing to gain by testifying against P.K. on this point, the County urged that P.K.'s testimony must be discredited.

The County argued that P.K. violated an unambiguous County rule calling for immediate discharge for a first offense when she falsified K.Z.'s elopement checklist. On this point, the County urged that the Arbitrator should not substitute her judgment for the County's regarding the discharge penalty. The County noted that its actions were neither arbitrary, capricious nor unreasonable and that it had followed proper procedures.

In regard to employee Woods, the County noted that she had been terminated by the County in an unrelated matter. Although Woods testified herein that she filled out checklists either at the beginning or the end of the shift, Woods admitted that she was aware her conduct was unacceptable, and that no one at the County ever told her that filling out checklists either at the beginning or end of the shift was appropriate. Woods also stated that she could not tell by looking at the lists when they had been filled out; that it was not sensible to fill out a checklist ahead of time and that the safety of the residents would not be protected if the lists were completed either at the beginning or the end of the shifts, as was Woods' practice.

The County argued that the purpose of the elopement checklists is not to have an extra piece of paper in the chart but rather to assure that the kind of elopement which occurred on July 19th does not occur at the Sunny Ridge Home. If an off-duty employee had not seen K.Z. walking down the street outside Sunny Ridge shortly after he eloped, there might have been a clear demonstration of the reasons for requiring that accurate elopement checklists be kept at

all times. Because P.K. had already filled out the checklist showing K.Z.'s location at 8:30, the County urged that K.Z. might not have been missed for some time, perhaps not until 10:30 or 11:00 p.m., when P.K. looked at K.Z.'s checklist again. In all the circumstances, the County urged that the grievance be denied and dismissed in its entirety.

The Union

The Union urged that the County did not have just cause to terminate P.K., citing the seven test for just cause enunciated by Arbitrator Daugherty. The Union noted that the County must prove that P.K. falsified records or committed a safety violation. In addition, by using the term "falsify" in its charges against P.K., the County must therefore prove that P.K. possessed both intent to falsify a record and knowledge that her actions constituted falsification. This, the Union asserted, the County failed to do in this case. 11/ P.K. admittedly filled out the elopement checklist sometime prior to 8:00 p.m. for the printed time slots for 8:30 p.m. through 10:30 p.m. but she intended to review and correct the list before the end of the shift at 11:00 p.m. This assertion is supported by the fact that P.K. filled in the time slots between 8:00 p.m. and 10:30 p.m. but left the 11:00 p.m. time slot on K.Z.'s checklist blank.

11/ The Union cited several cases concerning falsification of records in its brief. CITY OF OSHKOSH, CASE XLVII, NO. 30768, MA-2649 (MALAMUD, 7/83); THE TEWS COMPANY, CASE 25, NO. 55399, A-5599 (JONES, 5/98); LOCKHEAD AIRCRAFT SERVICE CO., 90 LA 296 (KAUFMAN, 12/87). These kinds of cases are generally driven by the specific facts proven and although instructive in a general way, I find them to be factually distinguishable from the instant case.

The Union argued that Kohlbeck's in-service of staff on July 19th, showed that employees did not know how to fill out the checklists. The Union also noted that there was no evidence that the County had in-serviced employees on the checklists prior to July 19th, such that P.K. was not aware that she had done anything wrong in filling out the checklist for K.Z. in advance on July 19th. Thus, the Union urged that the offense the County charged P.K. with should have been poor work performance and that ordinary discipline therefor would have corrected that offense. The Union also noted that P.K. worked one more night over the weekend before she was discharged, which the Union felt showed that her actions on July 19th were not so inappropriate that the County had to suspend or discharge P.K. immediately.

The Union analyzed the checklists contained in County Exhibit 10 and stated that they showed that there were cross-outs, changed statuses, time unaccounted for, mistaken initialing, initialing that appeared to have been done at one time because an arrow was drawn down from the top initial through several time frames, all of which showed that employees were filling out the elopement check sheets in various ways and that they were making mistakes. This

evidence indicated to the Union that there were so many mistaken entries, that the evidence from Woods, Doro and P.K. that they regularly filled out checklists ahead of time and corrected them later is plausible.

The Union argued that P.K.'s actions of July 19th did not constitute a safety violation. On this point, the Union noted that P.K. did not know where K.Z. was between 8:00 p.m. and 8:30 p.m. because the door alarm did not go off that night; that if the County truly wanted to

assure that K.Z. would not elope, it should have assigned an aide to watch K.Z. one-to-one; that P.K. was responsible for several other patients on the night of July 19th; and Nurse Mulloy admitted in her statement that she did not know that K.Z. had been placed on 30-minute elopement checks. The above evidence, the Union argued, indicated that P.K. was not responsible for what happened to K.Z. on the evening of July 19th.

Furthermore, the Union argued that the events of July 19th support P.K. and Woods' assertions that they saw K.Z. at 8:05 p.m. before break and that P.K. must have properly checked K.Z. at 8:00 p.m. The fact that K.Z. escaped thereafter and walked as far as he did in 30 minutes simply shows that he must have eloped after P.K. checked him at 8:00 p.m. but before 8:30 p.m. Thus, the Union urged that P.K. never intended to falsify any records; that by leaving the last entry of the evening (11:00 p.m.) blank, it showed that she intended to correct any incorrect entries at the end of the night.

In addition, there was no evidence that the County had ever trained employees to properly use the elopement checklists prior to July 19, until after K.Z. returned to the facility that night. In addition, because P.K. was allowed to correct K.Z.'s checklist upon her return to the facility with K.Z. on July 19th this met her responsibility to the County on his point. The Union urged that it had provided witnesses to support its claim of a past practice but that the Employer had no witnesses to support its contention that no such past practice regarding filling out checklists ahead existed. The Union argued that even if the checklist had been filled out correctly, this would not have stopped K.Z.'s elopement. Indeed, the Union wondered how the County could justify terminating P.K. when it did not even report K.Z.'s elopement to the State of Wisconsin.

Thus, the Union urged that the County had denied P.K. due process by failing to give her any prior notice that what she did regarding filling out K.Z.'s elopement checklist was wrong; that the County's investigation of the July 19th incident was unfair as CNA Emily was not asked any questions regarding her knowledge of the events; that nothing happened to others who had prepared their elopement checklists ahead of time, showing that P.K. was treated disparately; that it was unreasonable to terminate P.K. for not providing one-to-one coverage of K.Z. when that had not been her assignment on July 19th; and it was unreasonable to punish P.K. for the fact that the door alarms failed on July 19th. As the County failed to prove that P.K. had falsified records or committed a safety violation, the Union urged that termination was not deserved, that the grievance should be sustained in its entirety and that P.K. should be returned to work and made whole.

Reply Briefs

The County

The County urged that when K.Z. was discovered missing, there were false entries on his elopement checklist which were made by the Grievant and that because the entries were part of K.Z.'s medical chart they were "records." The County argued that intent to defraud is

not necessary to prove that P.K. has falsified records. On this point, the County cited several cases decided by WERC arbitrators. 12/ The County urged that the purposes for the elopement checklists are to keep patients safe and to assist in their treatment; and that filling these checklists out in advance does not accomplish these purposes.

The County disagreed with the Union's assertion that Kohlbeck's in-service of employees on the checklists was essentially an admission by the County that it had not acted properly or that it had failed to properly train employees prior to July 19th. Rather, the County urged that Kohlbeck's in-service was just a reminder and that she stated it was good nursing practice. Thus, there was no evidence to show that the County failed to in-service employees properly regarding the use of the checklist.

12/ Eagle River Memorial Hospital, Case 9, No. 41955, A-4417 (Shaw, 9/89); Milwaukee Athletic Club, Case 1, No. 53864, A-5458 (Honeyman, 6/96); City of Superior, Case 173, No. 58084, MA-10838 (Emery, 7/00). I find these cases to be factually distinguishable as well.

In the County's view, the errors found by the Union on County Exhibit 10 have nothing to do with this case. In this regard, the County noted that there were 4,000 entries on the various documents submitted as County Exhibit 10 and that the Union could not point to any list completed by Scott Doro or P.K. that actually supported their theories: that employees filled out the checklists in advance and changed them at the end of the shift to reflect reality. Furthermore, the County queried if there was nothing wrong with what P.K. did on July 19th, why was she worried about losing her job that night.

In sum, the Employer urged that it had no notice that employees were completing the checklists in advance; that there is no way to tell when cross-outs were made on these checklists, and therefore on the face of the documents, the County could not have known of inappropriate employee activity prior to July 19th. The fact that the County did not report the July 19th incident to the State is irrelevant to this matter as such a report is not necessary under State rules and regulations. The Director of Nursing's decision to terminate P.K. after the County's investigation was reasonable and the County's failure to get a statement from Emily was appropriate as she had already left the Home by the time K.Z. eloped. In all the circumstances, the County urged that the grievance be denied and dismissed in its entirety.

The Union

Initially, the Union noted that some of the facts stated by the Employer were misleading and the Union listed those areas. Further, the Union noted that the County's policy says that discharge may be appropriate unless there are mitigating circumstances. The Union urged that

there are mitigating circumstances in this case, in the form of the past practice of employees in filling out the checklist and the lack of employer training on how best to fill out those checklists. Thus, in these circumstances, termination of P.K. was too harsh a penalty.

Further, the Union urged that County Exhibit 10 does not demonstrate that Scott Doro's testimony was incredible. Rather, the evidence contained in County Exhibit 10 merely showed that Scott Doro did not have to change any of the checklists he was responsible for during the time frame covered by that exhibit, as Doro had anticipated K.Z.'s whereabouts correctly (based on K.Z.'s patterns).

The Union also urged that P.K. was a more credible witness than Kohlbeck. In this regard, the Union noted that Kohlbeck failed to immediately discipline P.K. when her activities came to light on the night of July 19th. Further, the Union argued that Woods and Doro had no incentive to lie in this case as that would have put them in harms way in the future. In the Union's view, P.K.'s worrying out loud about her job on July 19th did not prove that she was guilty of anything. Filling out checklists protects the Employer, not the resident, as these lists are required for State regulatory purposes. It is mere speculation when P.K. would have discovered K.Z. missing on July 19th, had the situation been different. Finally, the Union argued that the rule applied to P.K. regarding falsification of records or reports was ambiguous — that the County provided no details regarding its expectations concerning this rule and it failed to prove that it had clearly conveyed any instructions to employers regarding how to properly fill out elopement checklists. Thus, the Union urged that the grievance be sustained and that P.K. be returned to her position and made whole.

DISCUSSION

The first question that must be answered in this case in order to determine whether the County's termination of P.K. was appropriate is whether P.K. knew or should have known that filling out an elopement checklist in advance of the times printed thereon with the whereabouts of the resident was prohibited by County policy, as "falsifying reports or records." The dictionary definition of the word "falsify" is as follows:

> 1. To state untruthfully; misrepresent. 2. To alter (a document) in order to deceive. 3. To counterfeit; forge. . . . To make untrue statements; lie. The American Heritage Dictionary of the English Language, New College Edition,

(Houghton Mifflin Company, 1976), page 473.

Black's Law Dictionary, 6th Edition (West Publishing Co., 1990), at page 603, defines "falsify" as follows:

> To counterfeit or forge; to make something false; to give a false appearance to anything. To make false by mutilation, alteration, or addition; to tamper with,

> as to falsify a record or document. The word "falsify" may be used to convey two distinct meanings — either that of being intentionally or knowingly untrue, made with intent to defraud, or mistakenly and accidentally untrue. . . .

The facts of this case show that P.K. filled out K.Z.'s elopement checklist for the time periods from 8:30 through 10:30 (five half-hour periods) as if she had actually observed K.Z. at the times printed and at the places she indicated by number when she had not actually done so. Thus, the undisputed facts of this case demonstrate that P.K. filled out the elopement checklist for K.Z. on July 19th in order to leave the County with the impression that she had actually observed K.Z. at the times printed on the checklist, when in fact those times had not elapsed and she had not in fact observed K.Z. at the places she listed on the form. Thus, P.K.'s actions on July 19th amounted to falsifying K.Z.'s elopement checklist, as any lay person would understand the concept Certainly, P.K.'s actions gave a false appearance that she had actually performed the observations of K.Z. at the times printed on the checklist. Whether P.K.'s actions were intentional or knowing is insignificant. Rather, it is clear that P.K. knew the purpose for the checklist and that her actions on July 19th completely undermined that purpose, as she admitted herein. Furthermore, there is no question that the elopement checklists are "records," as they are kept in each resident's medical chart at the nurses' station and are required to be maintained by State law.

The record evidence herein showed that the County regularly in-services unit employees regarding County policies and that it has emphasized accurate record keeping by unit employees over time. Indeed, every witness who testified herein including P.K. knew that the proper way to fill out an elopement checklist is to check at or about the times printed on the checklists to make sure that the resident at risk for elopement is present and safe in the Home and to list his/her whereabouts in the Home (by number according to the key on the list) at the time observed. However, the County did not submit any evidence to show that it had specifically in-serviced employees regarding how to properly fill out elopement checklists prior to July 19th. In addition, the County's Wandering and Elopement Policy does not indicate how to fill out elopement checklists nor does it warn employees what will happen to them if they fail to properly fill out the checklists.

The question then arises whether P.K., in completing K.Z.'s elopement checklist in advance of the times printed thereon as if she had actually observed him in the Home at those times and places, was the type of misconduct which she must have known was improper, absent specific proof that the County had either instructed P.K. or other unit employees

regarding the checklists or warned P.K. and other employees in advance regarding the proper manner in which to fill out a checklist and what would happen to them if they failed to do so correctly.

I note that P.K. requested to change K.Z.'s elopement checklist after she returned with K.Z. and Sara Woods at 9:00 p.m. and that she and Sara Woods requested that they co-initial the changes on K.Z.'s form. In addition, I note that P.K. admitted that she was concerned for

her job on July 19th; that no County supervisor had ever told her to fill out elopement checklists in advance and then change the information thereon later; that in her statement to the County given July 19th after K.Z.'s elopement, she did not assert in that statement the defense that all CNA's fill out checklists in advance of the times listed thereon. In sum, the above admissions essentially support the County's assertion that P.K. knew that what she had done in filling out K.Z.'s elopement checklists in advance was prohibited by County Policy and was a serious offense for which she might be discharged.

The parties are at odds regarding a conversation which Nurse Mary Kohlbeck allegedly had with P.K. after P.K. returned to the Home on July 19th at approximately 9:00 p.m. In my view, Kohlbeck credibly testified that P.K. admitted that she did not know why she had filled out K.Z.'s elopement checklist in advance because she did not normally fill out checklists ahead of time. I find that Kohlbeck had a clear recall of her conversation with P.K. and that Kohlbeck had no reason to lie about her conversation with P.K. In addition, it is likely that P.K. would have made these admissions, as in stressful situations human beings often make admissions against their interests.

The Union offered several witnesses, including P.K., Scott Doro and Sara Woods, in an attempt to prove a past practice that employees had regularly filled out elopement checklists in advance and that the County had condoned this behavior. The evidence proffered by the both the County and the Union makes it difficult to answer the question whether such a past practice existed. However, after having studied the record herein in depth, I find that although the Union proved that employees working the PM and night shifts have filled out elopement checklists either in advance of their shifts or at the end of their shifts, the Union failed to prove that the County was aware of this practice and that it either agreed to it or condoned it over a long period of time.

Here, Nurse Mary Kohlbeck specifically stated that she was unaware that the employees were filling out elopement checklists in advance of the times printed thereon with resident whereabouts and she stated that if employees were completing checklists in this fashion, it would never be acceptable. Furthermore, although Scott Doro credibly testified 13/ that he regularly filled out checklists in advance and then corrected them by lining through incorrect information at the end of his shift, Doro did not offer any evidence to prove that County supervisors were aware of his practice and condoned it or acquiesced to it. In addition, P.K. failed to find any checklists among those in County Exhibit 10 that she could specifically point to, with the exception of one in April, which supported her assertions regarding her practice in

filling out checklists. In addition, Sara Woods indicated that it would not support the purpose of these checklists if employees were to fill them out in advance; that the important thing with an elopement checklist is to check at the intervals listed on the checklist and to fill in the form before the times listed makes theses checklists meaningless. Thus, there was no documentary evidence to support the Union's past practice claims and

(more importantly) the Union failed to get any admissions from any County supervisors to show that the County was aware of this alleged past practice regarding elopement checklist completion.

13/ I have found Doro credible. As an 18-year employee at the Home, it certainly is against Doro's interest to testify to filling out elopement checklists in advance or at the end of his shift. The fact that Doro was a Union official at the time of the instant hearing is, in my view, insufficient to detract from or diminish his credible testimony. I note that the County failed to impeach Doro in its questioning of him. On this point, I note that the fact that no checklists which Doro filled out for K.Z. contained in County Exhibit 10, showed his avowed practice of filling them out, may simply mean that for the four-month period covered by County Exhibit 10, Doro was not wrong in guessing K.Z.'s whereabouts at the printed times on each checklist. Doro's testimony is also bolstered by the fact that on several checklists, employees working the night shift put one number down (to indicate K.Z. was asleep in bed) and then put an arrow across several printed times to show that the same whereabouts number should apply. Finally, the quality and value of County Exhibit 10 is questionable, as there certainly were many lists which showed cross-outs and corrections.

The Union argued herein that because P.K. filled out K.Z.'s elopement checklist between 8:30 and 10:30 but did not fill in the 11:00 p.m. slot, she lacked intent to falsify a record. I disagree. Whether P.K. intended to review and correct the checklist before the end of her shift does not detract from the fact that when she filled in the checklist for the time slots of 8:30 through 10:30, she had not observed K.Z. in the places she stated she observed him in the Home and the times printed thereon had not even elapsed. Thus, at the very least, P.K. intended to make it appear as if she had filled out K.Z.'s checklist at the times listed indicating that she had observed him in the places in the Home that she listed, when in fact this was untrue. In my view, there is no question that P.K. intended to falsify K.Z.'s elopement checklist by her actions on July 19th.

The Union argued that Kohlbeck's in-service of staff on July 19th after K.Z. was returned to the Home following his elopement proved that the County never properly instructed employees how to fill out the checklists. I disagree. Nurse Mary Kohlbeck, whom I have credited in this case, stated that she did not in-service employees on July 19th regarding the elopement checklists because they were unaware of how to fill them out but rather because she felt that it was good nursing practice to address an important issue which had arisen in the Home immediately.

The Union also argued that the County failed to provide P.K. due process by failing to take a statement from part-time CNA Emily regarding her knowledge of what occurred on July 19th. In this regard, I note that Emily worked a short shift on July 19th, and left the facility at or around 8:00 p.m. and that Emily was not responsible to fill out K.Z.'s elopement checklist that evening. Thus, no violation of due process occurred herein because the County failed to interview Emily. The Union argued that P.K. was treated disparately and that other

employees who filled out their checklists in advance were not disciplined. On this point, I note that there was no evidence to show that the County knew that employees were filling out elopement checklists in advance prior to the incident which occurred on July 19th.

The Union also argued that the County's falsification of records or reports rule was ambiguous such that employees would not know what the County's expectations were regarding it. I disagree. The rule clearly states that a first offense will mean discharge. Also, every witness who testified in this case clearly understood that the purpose for completing the elopement checklists was to make sure that employees observed residents at or about the times listed on the checklists and noted the whereabouts of those residents subject elopement checklists so that the residents would remain safe and in the Home. In these circumstances, there can be no doubt that employees clearly knew that filling out an elopement checklist (a record or report) in advance of the times printed thereon with fictitious locations for the observation of the resident would constitute falsification of the elopement checklist.

Several issues were raised by the Union in this case which I find are irrelevant. Those Union issues include: whether the County door alarms and/or K.Z.'s Wanderguard were functioning properly on July 19th; whether the County should have placed K.Z. on one-to-one care on July 19th; why P.K. was allowed to change K.Z.'s elopement checklist to reflect reality after the fact and what impact this should have on this case; the actual time when K.Z. eloped from the Home on July 19th; and why the County did not report K.Z.'s elopement to the State of Wisconsin. These issues are essentially "red herrings" because I believe the record evidence indicates that P.K. falsified K.Z.'s July 19th elopement checklist. Making a determination who, if anyone, was responsible for K.Z.'s elopement and why and how K.Z. eloped that night the becomes irrelevant.

In a case such as this, arbitrators often consider the past employment history of the dischargee to determine whether there are any mitigating circumstances which might indicate that the discharge penalty was too severe. In this regard, I note that P.K. was hired in February in 2001 and only one year and five months later she was discharged; that P.K. was suspended for one-day in November of 2001 and suspended again for five days in March of 2002; that both suspensions were for safety violations regarding residents that P.K. was caring for on her shift; and that only the one-day suspension was grieved by P.K., leaving the five-day suspension standing. In addition, the suspension documents also clearly stated that progressive discipline would be applied for further infractions and that discharge would follow P.K.'s March, 2002, five-day suspension. Given P.K.'s short tenure at the County and her

employment difficulties during that time, I find that there are no mitigating circumstances in this case to cause me to set aside the County's judgment that discharge was called for here. As I have found that P.K. falsified K.Z.'s elopement checklist which constituted a record or report, I need not address the issue whether P.K.'s actions on July 19th also may have constituted a safety violation.

Based upon the relevant evidence and argument herein and my analysis thereof, I issue the following

AWARD

Sheboygan County did not violate the collective bargaining agreement when it terminated P.K. from employment. The grievance is therefore denied and dismissed in its entirety.

Dated at Oshkosh, Wisconsin, this 27th day of March, 2003.

Sharon A. Gallagher /s/

Sharon A. Gallagher, Arbitrator

SAG/anl
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