BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

SHEBOYGAN COUNTY
(Rocky Knoll Health Care Center)

and

LOCAL 2427 SHEBOYGAN INSTITUTION EMPLOYEES,
WISCONSIN COUNCIL 40, AFSCME, AFL-CIO

Case 356
No. 63070
MA-12493

(E. N. Grievance) 1/

Appearances:

Michael J. Collard, Human Resources Director, Sheboygan County, 508 New York Avenue, Room 336, Sheboygan, Wisconsin 53081, appearing on behalf of Sheboygan County.

Helen Isferding, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 1207 Main Avenue, Sheboygan, Wisconsin 53083, appearing on behalf of Local 2427, Sheboygan Institution Employees, AFSCME Council 40, AFL-CIO.

ARBITRATION AWARD

According to the terms of the 2002-03 Collective Bargaining Agreement between Local 2427, Sheboygan Institution Employees, Wisconsin Council 40, AFSCME, AFL-CIO (Union) and Sheboygan County (the County), the parties requested that the Wisconsin Employment Relations Commission appoint an impartial arbitrator to hear and resolve a

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1/ To protect the Grievant's privacy, I will refer to her by her initials and/or by the term "Grievant."

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dispute between them regarding the interpretation and application of certain provisions of the Agreement as they pertain to the five-day suspension of E. N. (the Grievant), imposed on June 16, 2003.

The Commission designated the undersigned, Commission Chair Judith Neumann, to hear and resolve the dispute. A hearing in the matter took place on Wednesday, March 17, 2004 and Wednesday, April 14, 2004, at the Rocky Knoll Health Care Center in Plymouth, Wisconsin. The parties filed written briefs following the hearing, the last of which was received on May 24, 2004.

ISSUE

The parties stipulated that the matter was properly before the Arbitrator and that the issue is as follows:

> Did Sheboygan County have just cause to issue a five-day suspension to the Grievant?
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> If not, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

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.
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> 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.

FACTS 2/

The Grievant began working for the County in March 1988 as a part-time Certified Nurse's Aide (CNA). At some point several years ago, she assumed full-time status and was upgraded from CNA to Attendant with a resulting increase in pay and responsibilities. The Grievant has generally worked third shift during her years with the County. The record reflects one prior disciplinary incident. In July 2001, while working at a different County facility, the Grievant left a resident unattended on a toilet for an inappropriate length of time, for which she received a one-day suspension on February 26, 2002 for a "safety violation." While the record contains no evaluation documents, the Grievant's most recent evaluation by supervisor Jean Kolosso and dated May 6, 2003, was described in the testimony of the facility's Director of Nursing as "fairly decent." The evaluation indicated that the Grievant was knowledgeable about managing the residents and required minimal supervision.

In July 2002, the County opened a new wing at its Rocky Knoll Health Care Center to house a population of mentally retarded and/or chronically mentally ill residents and the Grievant was transferred to work the night shift on one of the wings housing this population, i.e., "One West." The residents with whom she worked included severely mentally retarded, chronically mentally ill, and/or geriatric psychiatric residents, many of whom were nonverbal, delusional, severely disabled physically, muscle-contracted, and/or suffering from dementia. Some were unable to walk without equipment and/or assistance. Many of the residents were not elderly and many were long-time nursing home residents.

2/ The parties disagree fundamentally on the facts. The facts set forth in the following summary are my factual conclusions from the testimony and exhibits (which I will refer to as the record). It is neither a summary of the testimony nor a comprehensive description of the parties' differing views of the evidence.

At the time of the events giving rise to this case, One West housed approximately 28 residents. At one time, prior to the opening of the new wing, this population had been staffed on the third shift with three full-time and one part-time CNA's. However, by June 2003, staffing had been reduced to one full-timer (usually The Grievant) and one part-timer, whose identity varied from day to day. 3/ The Grievant shared most duties with the part-time CNA's, including personal hygiene, transfers and other ambulatory assistance, laundry, and responding to resident "call lights" and motion alarms. As a full-time Attendant, the Grievant also had some additional paperwork-related duties.

At all times, a Registered Nurse (RN) was on duty during the night shift with responsibility for the wing on which the Grievant worked as well as two other wings in the same "west" area. In addition there was usually a charge nurse overseeing the entire "West building" and a supervisor on duty and in charge of the entire facility. The RN was not generally present in a resident's room while the CNA's and Attendants performed their "cares" and other duties, although the RN would sometimes be needed to assist the CNA's in transferring residents from bed to bathrooms or into wheelchairs or walkers, and so forth.

All patient care providers, including part-time CNA's, are obliged and trained to report suspected patient abuse immediately. In the case of CNA's, such reports are commonly conveyed to the RN on duty, who would be expected in turn to report to the supervisor on duty, who would initiate an investigation. While RN's have authority to issue directives, they are not authorized to conduct formal investigations or impose discipline. Facility managers are expected to report suspected resident abuse to the state Department of Health and Family Services, which would conduct its own investigation and determine whether or not probable cause exists to believe the abuse occurred.

Barbara Andrews was generally the RN on duty during the third shift covering One West as well as wings Two West and Three West. She and night shift supervisor Jean Kolosso were aware of generalized complaints from other CNA's about the Grievant's alleged insensitivity toward or mishandling of residents, canceling call lights without responding, failing to perform her share of the work, and residents' reacting aggressively or fearfully in her presence. Even prior to the move to Rocky Knoll, CNA Lori Basler had reported to Ms. Andrews that Ms. Basler suspected that the Grievant had mistreated a mentally handicapped and physically contracted resident because when Ms. Basler returned from her vacation, during

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3/ The record suggests that the resident census may have been somewhat higher in early 2002 than it was by June, 2003. However, it is undisputed that the resident to staff ration was in some measure higher in June, 2003 than it had been earlier.

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which the Grievant had primarily cared for the resident on the third shift, Ms. Basler observed that the resident became highly agitated during cares until she realized that it was Ms. Basler and not the Grievant who was performing the cares. This concern was passed along to the supervisor, but the record does not reflect any management response.

In addition to the generalized complaints and concerns expressed among staff about the Grievant, several specific allegations regarding the Grievant's mistreatment of patients were brought to the attention of Ms. Andrews and/or supervisors during the several months prior to June 7, 2003. CNA Nancy Kletzein spoke with the RN about her observation that the Grievant was bruising certain contracted or otherwise physically resistant residents, who were also largely nonverbal, when performing peri cares on them. While the RN may have passed this complaint along to County supervisors, the record does not reflect that any action was taken in response. CNA Laura Lefeber-Elonen informed the day shift supervisor about a wound that she believed the Grievant had inflicted upon one of the contracted nonverbal residents while roughly prying the resident's legs open in order to perform peri cares. The record does not reflect what response the County may have made. CNA Janet Padour informed RN Andrews and supervisor Kolosso that she had observed the Grievant employing harsh language and rough methodology in prying certain residents' legs apart to perform peris. The record does not reflect the supervisory response, if any, but the Grievant was not addressed directly about the matter. On or about May 3, 2003, CNA Julie Rosenthal informed RN Andrews of an incident that date in which Ms. Rosenthal sought assistance in transferring a disabled resident by putting on the call light and, after the call light was cancelled without a response, Ms. Rosenthal was compelled to re-alarm the resident in order to approach the desk (where the Grievant and Ms. Basler were sitting) and seek assistance. Ms. Basler but not the Grievant then assisted Ms. Rosenthal. RN Andrews responded to this incident by making a general announcement that all call lights were to be answered before being cancelled. However, no one spoke to the Grievant directly about the matter.

On or about May 27, 2003, in the early morning hours, an ambulatory resident, consistent with his usual habits, got out of bed and approached the staff desk for a drink. The Grievant was known to dislike this resident. After sitting for a while in the nearby alcove, the resident asked to be taken back to bed. The Grievant snapped at him, "You found your way out here, you can find your way back." However, CNA Janet Padour, who was also on duty, assisted the resident back to bed. As they approached his room, the Grievant, who was nearby performing chores, again sharply and rudely directed Ms. Padour, within earshot of the resident, not to "dare cover him up, he can do it himself." Ms. Padour nonetheless adjusted the bedclothes, settled the resident in bed, and covered him. The Grievant then stated to Ms. Padour that she disliked the resident because he had sexually abused her (the Grievant's) neighbor – information that was inaccurate, not supported by information on the resident's chart, and, in any event, protected by patient privacy rules. (In fact, prior to the resident's

stroke, he had no history of any sexual abuse or deviance, but after his stroke had occasionally been sexually suggestive to adult staff at his earlier placement, which the Grievant had heard through the grapevine). Later that night, while Ms. Padour and the Grievant were engaged in another chore, they noticed a call light from a resident's room who generally did not seek assistance by means of a call light. Ms. Padour wanted to respond, but the Grievant deterred her, saying the resident "could wait." Ms. Padour was still angry with the Grievant about the earlier incident and did not wish to challenge her on the call light issue. As it happens, it was RN Andrews who had hit the call light as she found herself needing assistance with a resident, and she was kept waiting approximately eight minutes before someone responded. Ms. Andrews reported this incident to supervisor Kolosso, who then "spoke with" both Ms. Padour and the Grievant. The record also reflects that supervisors were aware that the Grievant and sometimes other CNA's skipped certain incontinent residents during rounds. Ms. Andrews (and perhaps other supervisors) admonished the Grievant and the other CNA's never to do so. The record does not reflect incidents of canceling call lights or skipping rounds after these admonishments.

On approximately four occasions in the months leading up to June 7, 2003, RA Andrews discussed concerns about the Grievant with supervisor Kolosso and was directed to "keep your eyes and ears open." On or about June 5, 2004, supervisor Kolosso discussed concerns about the Grievant with the County's Director of Nursing and Kolosso was directed to monitor the Grievant more closely for specific incidents. When part-time CNA's mentioned concerns to RN Andrews, she would remind them of their duty to report abuse and ask them if they were prepared to submit a written report. Several part-timers were fearful of the Grievant and/or uncertain about the scope of "abuse" and the consequences of filing abuse reports. Prior to June 8, 2003, no reports of resident abuse or neglect were filed by supervisors or co-workers regarding the Grievant.

During the early morning hours of June 8, 2003, part-time CNA Virginia Medina, still a probationary employee, was on duty on the third shift with the Grievant when a resident's alarms went off, indicating she was attempting to get out of bed. This resident had difficulty sleeping and frequently got up during the night. She was relatively verbal but not ambulatory and needed to be assisted in and out of bed. The Grievant rudely and loudly directed the resident to go back to bed and stated to the effect, "We aren't going to play your games." While Ms. Medina was assisting the resident to the bathroom and back to bed, the resident stated several times, "[The Grievant] is mad at me," causing the Grievant to snap "change the subject," while Ms. Medina tried to reassure the resident that no one was angry with her. Later that evening, another incident occurred when the Grievant and Ms. Medina were assisting a resident, who was mentally limited, nonverbal, and physically stiff, to get up and dressed in the morning. This resident did not understand or would forget that she needed to walk after being helped to a standing position and would sometimes sit back down on the bed

unless she was coaxed and assisted in taking the first few steps. Ms. Medina's hands were full of towels and linens and she was unable to assist in getting the resident out of bed. The Grievant took the resident harshly by the hands and pulled her up and forward so that the resident stumbled and fell forward, frightening the resident and causing Ms. Medina to worry that the resident may have been injured. The Grievant then rudely told the resident to "get up." The Grievant was known to dislike both of these residents. Ms. Medina wanted to report what she viewed as these two incidents of abuse that same shift, but did not do so because the Grievant was always hovering close by when Ms. Medina was near the charge nurse on duty. Instead, Ms. Medina reported the incident orally to the day shift supervisor as she (Ms. Medina) left work early that morning. When Ms. Medina reported for duty that evening, RN Andrews directed her to write a statement, which Ms. Medina did.

The facility's Director of Nursing and Director of Social Services conducted an investigation on June 9, 10, and 11, consisting of oral interviews with the Grievant, Ms. Medina, and several of the Grievant's co-workers and supervisors. During these interviews, several co-workers reported that the Grievant used a harsh voice and manner, especially with certain residents and employed unnecessarily harsh methods to accomplish peri cares, such as forcibly prying the legs open and yelling "C'mon, spread." After the first round of interviews elicited information from CNA Padour that the Grievant had mistreated a second resident on May 27 and had also violated that patient's right to privacy, the administrators interviewed the Grievant a second time to obtain her response to these new allegations. The Grievant again denied misconduct but became too emotional for administrators to request a second written statement. On the other hand, neither the Grievant nor the Union offered to provide a second written statement nor did administrators refuse to accept one.

The County concluded that the Grievant had engaged in misconduct and issued a suspension report dated June 16, 2003, that stated as follows:

> On 5/27/03, [the Grievant] rudely told Resident #100961 that "you found your way up here, you can find your way back." She also stated to her coworkers that (Resident #100961) "You better not cover him up, he can do it himself" after the coworker returned him to bed. This occurred after providing personal information about the resident to her coworkers and stating she did not like him because of the personal information. On the morning of 6/8/03, [the Grievant] pulled Resident #300144, forcibly by the arm to get the resident out of bed without explaining what was going to occur prior to the transfer. The resident was pulled hard enough to force several steps forward to maintain balance. Numerous incidents of forcibly and rapidly pulling residents legs apart have been reported to enable perineal care to be completed. Rudeness, sharp tone of voice, and raising of her voice to residents predominately occurs during cares

> and interactions with residents. [The Grievant] has purposefully not attended to incontinent residents, skipping these resident's rooms and directing others to do the same on her shifts. [The Grievant] directs coworkers to complete her assigned duties. [The Grievant] does not answer call lights promptly."

The Grievant was suspended for five days without pay, transferred to work with a different population of residents, and reduced from the rank of "attendant" to "CNA," with a consequent loss of approximately $0.27 per hour in wages.

DISCUSSION

In this case, both parties in their briefs have addressed the "just cause" issue in terms of the seven elements first put forward by Arbitrator Daugherty in MOORE'S SEAFOOD PRODUCTS, 50 LA 83 (1968), i.e., forewarning that the conduct could lead to discipline, reasonableness of the work rules allegedly violated, completeness of the investigation, fairness and objectivity of the investigation, sufficiency of the evidence that the misconduct occurred, evenhandedness of the employer in enforcing its rules, and appropriateness of the degree of discipline in light of the nature of the misconduct and the employee's past record. Accordingly, I will follow suit and apply these seven factors in determining whether the employer had just cause to suspend (and demote) the Grievant, keeping in mind that the County has the burden of producing the necessary evidence and persuading the arbitrator that it amounts to just cause.

1. Forewarning of the Disciplinary Consequences

This is the weakest and most troubling element in the County's case. The County essentially relies upon the Grievant's acknowledgement at hearing that, if she were found to have engaged in the alleged misconduct, she would deserve discipline. 4/ While true, this is not entirely persuasive. An employee may have some consciousness that her actions are wrong without necessarily comprehending their gravity in the eyes of the employer. In this case, the Grievant had engaged in a pattern of harshness and petty cruelties to her charges, with the general and sometimes specific knowledge of her superiors, even before July 2002, when she

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4/ Throughout this award, I will refer to the allegations as relating to "misconduct" rather than "abuse" or "neglect", as the latter are terms of art bearing crucial consequences under state law regulating nursing homes and CNA licensure. I have no authority and do not intend to construe any of the conduct attributed to the Grievant as "abuse" or "neglect" within the meaning of state law or regulations.

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was transferred to the newly opened wing at Rocky Knoll, as related in detail in the above Facts. It is understandable that County supervisors would want concrete and specific incidents and/or written first hand reports before imposing discipline. However, their delay and passivity in responding to the widespread sense that the Grievant frequently behaved inappropriately with residents could have misled the Grievant into a sense of complacency, a sense that her behaviors, if not necessarily approved, were somewhat tolerated, and even if wrong, were not so wrong as to warrant discipline. The record reflects some belated supervisory attention to the Grievant's behavior, but there is no indication that the Grievant was made aware of this ostensible additional scrutiny. As late as May 6, the Grievant received a formal written evaluation that evidently did not apprise her of any supervisory concerns and suggested she worked well with minimum supervision. The fact that the Grievant could respond to explicit directives or warnings is evidenced by her apparent compliance with the call light and rounds-skipping verbal directives that superiors provided in response to the May 27 incident with RN Andrews and earlier complaints from CNA's.

On the other hand, the Grievant had been suspended previously and relatively recently for inappropriately handling a resident. The Union argues that the two suspension incidents were dissimilar in nature, the first resulting from conduct that was more in the nature of inadvertence or neglect, while she is accused of more deliberate mistreatment in the instant case. I do not see the incidents as so dissimilar. The first suspension should have put the Grievant on notice that there would be disciplinary consequences for mistreatment of residents, whether neglectful or deliberate. In my view, the County's delay in responding to its general and/or specific knowledge that the Grievant was treating residents inappropriately would have precluded the County from discharging her for the offenses underlying the instant grievance. However, I also conclude that the Grievant reasonably could have expected the five-day suspension she received and therefore this first element of the seven-part test is met.

2. <u>Reasonableness of the Work Rules</u>

There is no serious dispute that the County could reasonably expect its staff to treat residents, especially this particularly vulnerable population of residents, with patience, kindness, and respect and that the conduct of which the Grievant is accused violated these reasonable and important expectations. While the Grievant attempted to justify her methodology for performing peri cares (prying the legs apart) and for pulling Roz to a standing position, it is apparent from the Facts, above, that I have not accepted her benign explanation and have instead credited the several CNA's who testified, most with some timidity and reluctance but also with firmness and directness, that both of these operations could be performed differently (e.g., performing peri cares on females from behind) as well as more patiently and kindly. This element is satisfied.

3. Completeness of the Investigation

The completeness of the County's investigation, comprising extensive interviews with numerous coworkers and supervisors, is not seriously in issue. The Union faults the County's failure to obtain a second written statement from the Grievant, as part and parcel of its second follow-up interview with her, but it is clear that the County adequately sought her point of view and did not prevent any input she wished to provide. This element is satisfied.

4. Fairness and Objectivity of the Investigation

The Union argues that the investigation was unfair because the County's main investigator (the Director of Nursing) was also the individual who determined that discipline should be imposed and at what level. The Union also suggests that the individuals conducting the investigation articulated their questions in a manner that would tend to elicit negative information about the Grievant. Finally the Union posits that the investigation was a witch-hunt instigated by a set of disgruntled part-time CNA's who disliked working with the Grievant because they felt they were doing more than their share of the work.

The evidence does not support these contentions. The investigators took care to ask open-ended questions and to make sure that the written statements were in the witnesses' own words. While it is likely that at least some of the witnesses realized from the context of the questions that the investigation related to the Grievant, that in itself does not impeach the objectivity of the information provided. Regarding the "witch hunt," such concerns are always possible in a situation where a number of individuals appear to be coalescing against a coworker, especially where the coworker has some sort of superior status (in this case, the Grievant being both full-time and considerably more senior). However, the eyewitness accounts presented both in writing and in testimony are both too detailed and too diverse in their points of emphasis to be the product of rumor, innuendo or imagination. On the contrary, I find these accounts poignant in the sincere concern they reflect for the residents in their care under such difficult circumstances. I am persuaded that their accounts are true and that the investigation does not suffer from the flaws the Union has alleged.

5. Sufficiency of the evidence of the alleged misconduct

As is apparent from the Facts set forth above and the discussion regarding the preceding elements of the parties' just cause test, I have concluded that the County has supported its central allegations with sufficient evidence. There are two exceptions – the allegations that the Grievant ignored call lights and skipped rounds. While I am satisfied that this misconduct did occur, it appears from the evidence before me that the Grievant corrected

these deficiencies when they were brought to her attention. Hence, absent evidence that they continued to occur, I do not find them sufficiently supported to form a basis for the discipline.

Regarding the other misconduct (unnecessarily rough peri cares, verbal and/or physical harshness with Resident # 100961 and 300144, and inappropriate disclosure of information regarding #100961), the evidence is more than sufficient. To rebut the first-hand accounts of co-workers, the Union essentially offers the testimony of the Grievant herself, who either outright denied the behaviors or attempted to explain them as part of approved and appropriate care routines. For example, the Grievant claimed that it was necessary to push and hold open the legs of contracted residents in order to properly clean the area, especially with one resident who was prone to urinary tract infections. She denied doing so in a rough manner or causing any bruising or injuries. She contended that Resident # 300144, who stumbled and fell forward in being pulled to her feet, had failed to plant her feet properly, partly because the other attendant (Ms. Medina) was holding linens instead of assisting in the transfer. These explanations are directly at odds with the testimony of witnesses that I found to be credible. It follows that I am not persuaded by the Grievant's explanations. In particular, regarding the peri cares, other CNA's persuasively pointed out that these cares could be performed more easily and with less offense to the female residents if they were lying on their sides and approached form behind. Accordingly, the County has also satisfied this element.

6. Evenhandedness in Enforcing the Rules

The County argues that, if anything, it responded more leniently with the Grievant than it normally would respond to the kind of misconduct it found she committed. The record in fact contains no evidence one way or the other about how the County has responded to similar allegations regarding other employees. While the County bears the overall burden of production in just cause disciplinary cases, on this particular issue it would be incumbent upon the Union to call the employer's fairness into question in some manner. The Union has not done so. Accordingly, I conclude that this element is also met.

7. Appropriateness of the Degree of Discipline

As just noted, the County's position is that it normally would discharge an employee for the misconduct involved in this case. Instead it considered the Grievant's considerable length of service in meting out a five-day suspension. Because I believe the County bears some responsibility for allowing the Grievant to develop some complacency regarding her inappropriate treatment of residents, I would have had difficulty concluding that the "punishment fit the crime" if the County had discharged her. However, under the circumstances, which include a previous one-day suspension for patient mistreatment, I view

the five-day penalty as an appropriate corrective step and a properly measured response to the misconduct.

However, the County's passivity in responding to the Grievant's earlier and ongoing behaviors does warrant modifying the penalty it imposed by removing the permanent loss of pay that accompanied the Grievant' transfer to a different work location and demotion. The transfer itself was certainly a sensible and prudent response which I would not consider disturbing, since it placed the Grievant in a situation where she would work with residents who were more able to assert their needs and required somewhat less patience. The permanent loss of pay, however, seems an excessive penalty for an employee of the Grievant's tenure. Accordingly, I will direct the County restore her wages to what they would have been but for the County's action in reducing her wages on June 16, with appropriate back pay.

AWARD

The grievance is denied in that the County had just cause to impose the five-day suspension and transfer upon the Grievant. However, the grievance is granted to the extent that the County's permanent reduction in the Grievant's wages on and after June 16, 2003 was without just cause. The County will restore the Grievant's wages retroactively to the level they would have been had the County not reduced them on June 16, 2003, with all appropriate back pay.

Dated at Madison, Wisconsin, this 23rd day of August, 2004.

Judith Neumann /s/
Judith Neumann, Arbitrator

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