BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

AFSCME LOCAL 723, AFL-CIO

and

JEFFERSON COUNTY

Case 118
No. 63281
MA-12536

(Baker Termination Grievance)

Appearances:

Bill Moberly, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, on behalf of AFSCME Local 723, AFL-CIO.

Philip C. Ristow, Corporation Counsel, on behalf of Jefferson County.

ARBITRATION AWARD

AFSCME Local 723, AFL-CIO, hereinafter the Union, and Jefferson County, hereinafter the County, jointly requested that the Wisconsin Employment Relations Commission provide a panel of staff arbitrators from which the parties select an arbitrator to hear and decide the instant dispute between the parties, in accordance with the grievance and arbitration procedures contained in the parties' labor agreement. The undersigned, David E. Shaw, of the Commission's staff, was selected and designated to arbitrate in the dispute. A hearing was held before the undersigned on April 16, 2004 in Jefferson, Wisconsin. There was no stenographic transcript made of the hearing and the parties submitted post-hearing briefs in the matter by June 23, 2004. Based upon the evidence and the arguments of the parties, the undersigned makes and issues the following Award.

ISSUES

The parties stipulated to the following statement of the substantive issues:

Did the County have just cause to terminate Debbie Baker from her job at Countryside Home?

If so, what is the appropriate remedy?

The County also raised the following procedural issue:

Is the request for arbitration timely? 1/

1/ Additionally, the County asserts that if the request for arbitration is found to be timely, the Union's delay in making the request should be taken into account with regard to any award of back pay that would be awarded if the Grievant prevails.

CONTRACT PROVISIONS

The parties' agreement contains the following provisions, in relevant part:

Article 3 – Management Rights

3.01 Rights: The County possesses the sole right to operate the County and all management rights repose in it, subject to this Agreement. These rights include, but are not limited to, the following:

. . .

(e) To suspend, discharge and take other disciplinary action against employees for just cause;

. . .

These rights shall be applied equitably to all employees. Nothing contained herein shall be used by the Employer to discriminate against any employee because of his or her representation by the Union. The above rights shall be exercised consistent with this Agreement and the parties agree that the Union does not forfeit any of its rights under Chapter 111 of the Wisconsin Statutes.

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Article 6 – Grievance Procedure

6.01 Definition: A grievance is defined to be any dispute which may arise between the Employer and an employee, or the Employer and the Union, involving the interpretation and/or application of this Agreement.

6.02 Procedure: Grievances shall be processed in accordance with the procedure outlined herein. All times set forth in the Article, unless otherwise specified, are working days and are exclusive of Saturday, Sunday and any holiday recognized by this Agreement. All time requirements set forth in this Article may be waived or extended by mutual written consent of the parties. A grievance affecting more than one department may be submitted in writing to the County Administrator and the processing of such grievance shall commence at Step 2.

Step 1. The grievance shall be reduced to writing and submitted by an aggrieved employee and/or a representative of the Union to the department head within thirty (30) calendar days of the occurrence. Grievances not submitted within the above time limits shall be considered waived, except that, any of the above time limits shall be extended for good cause upon request of the Union. A meeting between the parties shall be held within ten (10) days of the submission of the written grievance. The department head shall respond in writing to the aggrieved employee and the Union within ten (10) days following said meeting.

Step 2. If the grievance is not resolved at the first step, the employee and/or the Union may appeal the written grievance to the County Administrator within ten (10) days from the date the written decision of the department head was received or was due. The parties shall meet within fifteen (15) days at a mutually agreeable time and place to discuss the grievance. Following said meeting, the County Administrator shall respond in writing within ten (10) days to the employee and the Union.

Step 3. Grievance Mediation: The parties may jointly participate. The parties will attempt to agree on a selection of a mediator in advance of the request to the WERC should either party not agree to grievance mediation, either party may petition for arbitration.

Step 4. Arbitration:

A) General: If the grievance is not settled at the third step, the Union may proceed to arbitration by informing the County Administrator, in writing, within fifteen (15) days from the date the written response of the County Administrator was received or was due, that they intend to do so.

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Article 9 – Discipline

9.01 Standard: The Employer shall not suspend, discharge or otherwise discipline any non-probationary employee without just cause. When such action is taken against an employee, the employee and the Union will receive written notice of such action at the time it is taken, except that written notice of an oral reprimand shall be provided to the employee and the Union within two (2) working days after the action is taken. Notice of discipline shall include the reasons on which the employer's action was based.

9.02 Representation: When the Employer is going to discuss a matter of discipline or potential discipline with an employee, the employee shall be advised of his/her right to have a steward or other union representative present during the discussion.

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BACKGROUND

The County maintains and operates a health care facility, the Countryside Home, in Jefferson, Wisconsin. At the time in question, the Home's Administrator was Candace Lagerfeldt. The Grievant, Deborah Baker, had been employed at the Home for 15 years as a Licensed Practical Nurse (LPN). The Grievant's prior discipline consisted of being written up in 2003 for sleeping on the job.

On June 23, 2003, the Grievant was working as an LPN and Team Leader on Unit 3 West, an Alzheimer's floor with 24 residents on it. The Grievant was not normally assigned to this floor, but is assigned to the floor 4 to 6 shifts a month. The Grievant's shift started at 10:30 p.m. and there were two Certified Nursing Assistants (CNA's) on with the Grievant and a third CNA, Janet Everson, who comes in at 5:30 a.m. to assist with restless residents while the other two CNA's get residents up and dressed. The Grievant was responsible for passing out medications and was in the process of doing so at 5:45 a.m. when the events in issue occurred.

Resident O.A. was admitted to the Home in April of 2003 with a fractured pelvis and pubis and assessed at high risk for falls. A care plan was developed for O.A. which required the use of a bed alarm at all times. The alarm is clipped to the resident's gown with a string that is attached to the bed rail. When the alarm is attached in this manner, if a resident starts to fall out of bed or tries to get up, the string is pulled and the alarm is set off. What occurred at 5:45 a.m. on June 23, 2003 with regard to resident O.A. is in dispute.

The Grievant testified that CNA Everson informed her that O.A. was yelling and that if the Grievant was going to give O.A. a suppository, she should do it then. O.A. was to get a suppository and the Grievant administered it to her. O.A. kept trying to sit up and take off her gown. At that time, CNA Everson left the room due to another resident's alarm going off across the hall from O.A. According to the Grievant, she stayed with O.A. for approximately 5 minutes. During that time, the Grievant left O.A.'s room to get her a dry gown, as O.A.'s was soiled and there were no clean gowns in the room, and then put a dry gown on O.A., who kept trying to take it off. The Grievant testified that she left O.A. to answer another alarm that had gone off earlier, but which was no longer going off, and that O.A. had her gown on when the Grievant left. The Grievant yelled to Everson, who was taking care of the resident across the hall from O.A., to "hurry up" because O.A. was not keeping her gown on. The Grievant testified she was a little upset with Everson for not just cleaning up the other resident and getting back to O.A., but did not think this was an emergency, since Everson had said O.A. did this all the time, and O.A. had not fallen. The Grievant was one door down from O.A.'s room when she heard Everson, who was outside O.A.'s doorway, say, "Oh, she's on the floor." The Grievant testified that she did not hear O.A. fall or hear her alarm go off. O.A. was screaming and trying to sit up and said her hip hurt and that she had to go to the bathroom. The Grievant felt that she had to get O.A. off the floor and onto the commode. The Grievant supported O.A.'s hip, and with Everson's help (at the Grievant's direction) placed O.A. on the commode. After O.A. was finished on the commode, the Grievant, Everson and another person placed her in her bed. O.A. was still screaming in pain and at that point the Grievant thought O.A.'s hip might be broken, which was subsequently found to be the case. The Charge Nurse was then called. The Grievant completed an "incident report" regarding O.A.'s fall that indicated a bed alarm was required and circled "D-Removed or slipped out on own" and under "Factors" did not check off "Left alone when supervision required."

The Grievant also testified that she starts passing medications at 5:00 a.m. and that she is supposed to be done doing so by 6:00 a.m.; however, she conceded she is often not done on time and has not been disciplined for it. She further testified that the charge nurse on that day had complained in the past that the Grievant was spending too much time with residents' care when she was passing medications and not getting that task completed on time. According to a document provided to all of the nurses at the Home at an in-service, med passes are to be completed within one hour of the designated time.

Janet Everson testified she comes in at 5:30 a.m. to help residents get up, primarily the residents who are restless and in danger of falling. According to Everson, when she got off the elevator that morning, she could see O.A. sitting on the side of her bed with her gown off and yelling. She went in the room to get O.A. up, but the Grievant told her not to, as O.A. needed to be given a suppository. The Grievant and Everson laid O.A. down and gave her the suppository. Then, the alarm of the resident across the hall went off and Everson went to assist her. That resident was sitting up sideways in bed and Everson got her up, got her cleaned and dressed. Approximately five minutes after she left O.A.'s room, while she was assisting the resident across the hall, the Grievant told her that she kept putting O.A.'s gown on, but O.A. kept taking it off, and that the gown was off. The Grievant said she was going to go on with passing out meds. Everson testified that she did not hear any alarms going off at this time. Everson was finishing getting the resident across the hall secured in her chair when she heard a "thud". Everson went to O.A.'s room and saw her on the floor and yelled to the Grievant who was at her medicine cart in the hallway three doors down and across the hall. O.A. was sitting on the floor yelling that she broke her hip and started to have a bowel movement so the Grievant and Everson placed O.A. on the commode. Everson conceded that she had not actually seen O.A. with her gown off when the Grievant had left O.A.'s room and had said that O.A. kept taking off her gown.

Lori Hersrud, an LPN, and also the Union Steward, testified that she talked to the Grievant on June 23rd about O.A.'s fall. The Grievant said she had gone into O.A.'s room with Everson to give O.A. a suppository. O.A. was restless and the alarm of the resident across the hall went off and Everson left to attend to her. O.A. was still restless and the Grievant told her to be patient as the CNA (Everson) would be back shortly. According to Hersrud, the Grievant told her that O.A.'s gown was off when she left O.A., and then said something to the effect of "What am I supposed to do, I had my meds to pass." Hersrud testified she told the Grievant that she should have got someone to stay with O.A. Hersrud testified that the Grievant told her she heard a "thud" and knew O.A. had fallen, and that both alarms were going off – O.A.'s and the resident's across the hall. On cross-examination, Hersrud reiterated that the Grievant told her that O.A.'s gown was off when she left O.A.'s room.

The Grievant, Everson and Hersrud filled out investigation reports on June 25, 2003 at the direction of the Home's Director of Nursing, Susanne Johann. The Grievant was called by Johann and told there was an investigation, that she was suspended with pay until the investigation was completed, and that she was to come in as soon as possible. The Grievant came in and filled out a report in the presence of Johann and the Union President. According to the Grievant, she asked Johann how much she should write, and was told to write what had happened up to the time O.A. fell. The Grievant completed her report and gave it to Johann, who said she would give it to the Home's Administrator, who would make the decision.

The Grievant's investigation report stated, in relevant part,

> "As I was leaving res. sat up and removed her gown which has clip alarm on it. I replaced her gown and explained to her that we would get her up in a few minutes. I told CNA she needed to be watched because if she took her gown off, we couldn't hear her alarm. . . The CNA was across the hall and I left the room to give another medication (suppository) to another resident. . ."

In her investigation report, Everson stated, in relevant part,

> "The resident across the hall was trying to get out of bed and her alarm was already off so I told the nurse I was going to do her first then. She also has to be stayed with." The nurse came over and said she gave her the suppository but didn't put her gown back on which left her without an alarm. . ."

Hersrud stated in her investigation report,

> "While receiving report from Debbie Baker LPN, we further discussed fall earlier in the morning. States both alarms were going off. Janet went by (H), I had to give her a suppository, she had her gown off. I told her to wait, the CNA was busy. I had meds to give. I no more than got to the day room and I heard a thud. I knew it she was on the floor. What was I suppose to do, now you know why I can't get done on time."

The Grievant was later called by Johann and told that she was to come to a meeting. On June 26, 2003, a meeting was held at which the Home's Administrator, Candace Lagerfeldt, DON Johann, the County Administrator, the Administrative Secretary, the Union President, Sharon Endl, and the Grievant were present. Lagerfeldt told the Grievant her employment was being terminated and that the matter had to be reported to the State Bureau of Quality Assurance, who would investigate. According to the Grievant, Johann had not asked her any questions, just told to write up her report, and that at the meeting, Lagerfeldt did not ask her what had happened. The following are the minutes of the June 26th meeting, in relevant part:

> LAGERFELDT: Recently it was reported to us and you confirmed, there was concern about a woman resident who had fallen out of bed and hence was hospitalized with a fractured hip. We interviewed other people on that unit, on that shift, at that time. As a result of our investigation we have found the woman was left in an unsafe condition by you. Safety is one of our very most aspects (sic) in the care of residents. The alarm she needed to have on was care planned. It was the decision of the interdisciplinary team that she needed it.

When it was not put on, it was in violation of our policy and was not protecting her safety.

Three things are going to happen:

1. Your employment will be terminated.

2. This needs to be reported to the State Bureau of Quality Assurance and they will investigate, call you or come here.

3. You will get a formal letter from us stating that we are terminating your employment and why.

JOHANN: Terri Palm will send you a letter as to your rights of separation.

BAKER: Are you saying I am lying? I left her without a gown but asked an aide to keep an eye on her. We had several alarms going off and residents in positions that they needed assistance.

LAGERFELDT: In investigating, we interview as many people as we can and take into consideration all information we are given. For example if a resident says he hit me and they are alert, we take the information, use our best judgment and the tie goes to the resident and the person is disciplined accordingly. In this case we took the majority of information and made our decision.

JOHANN: You verbally told two staff people you left her without a gown and call light.

BAKER: You mean alarm.

JOHANN: Yes, without an alarm and gown. You told it to staff.

LAGERFELDT: Am I saying you are lying? No. am I taking all the information, some of it is conflicting. That is what we based our decision on. Any other questions?

BAKER: No.

ENDL: You did not do it intentionally or willfully, but unfortunately it happened.

BAKER: And if it would have been July 1 there would have been med techs and I would have been able to stay with her. I have had a lot of pressure put on me because I am not done with passing meds by 6:30 because I do answer lights and intervene and the pressure is alarming on that unit. I run when I see someone is in need of care.

I know I had to give another person a suppository before he got up. On any other floor a suppository is not as important. I was chastised by Mary Lou for not giving suppositories on the 3rd day. It is a big thing when you give a suppository and if I don't she gets very angry. There is a lot of pressure working with her.

I did stay with this woman for awhile and they tell me she is always like this. I just did not have time.

I did call 2 to finish the med pass so I could do what I had to do. Lori came up and took over when she could. Mary Lou would not have done that. There has been a lot of pressure over the years because I do take care of the residents first. This would probably have happened to her anyway.

LAGERFELDT: I want you to be very clear that we are not saying that you caused the fall and the broken hip. We are saying you did not follow policies of the facility and left your resident in a compromising situation and unfortunately it resulted in a fall. We are not saying having the clip on would have kept her in bed.

Your action was of neglect in not following policy and keeping her safe according to the care plan and facility policy.

. . .

On June 27, 2003, the Grievant was issued the following letter from Lagerfeldt, which stated, in relevant part:

Dear Ms. Baker:

This letter is to inform you that I have made a mandatory report to the Bureau of Quality Assurance regarding the incident of your leaving a resident unattended on June 23, 2003.

I have reported to the Bureau of Quality Assurance the circumstances of the incident, investigation findings and my conclusion that your actions, while exercising poor judgment in leaving the resident unattended in an unsafe manner, substantiated that this was an intentional omission or intent of caregiver neglect on your part.

You will receive correspondence directly from the State of Wisconsin Bureau of Quality Assurance Caregiver Regulation and Investigation Section regarding the disposition of the two reports made to them.

Your employment at Countryside Home was terminated immediately. Please return any keys issued to you at your time of employment to the Human Resources Department.

. . .

A report was filed with the State's Bureau of Quality Assurance regarding O.A.'s fall and injury. The State's investigation resulted in the issuance to the Home of a federal deficiency and a State Class B violation based on the actions taken after O.A. had fallen, and a State Class B violation based on the finding that the Grievant left O.A. unattended and without the alarm attached, resulting in O.A. exiting her bed unattended.

A complaint against the Grievant was filed by the Bureau of Quality Assurance with the State's Department of Regulation and Licensing. The Grievant was advised in September of 2003 by the State's Nursing Board that the complaint was before the Board. By letter of April 15, 2004, the Grievant was informed by the Department of Regulation and Licensing that:

The purpose of this letter is to inform you of the results of the review of a complaint we received against you referred by the Division of Disability and Elder Services, Bureau of Quality Assurance.

The details of the complaint, including information which may have been obtained by us, were reviewed and evaluated by a screening panel. Screening panels include members of the relevant profession, legal staff and other department staff.

The screening panel has decided the information does not indicate a violation of the Wisconsin Administrative Codes and/or Wisconsin State Statutes which regulate the practice of your profession.

> As a result of the evaluation process, a decision has been made by the screening panel not to take any action based on this complaint.

A grievance was filed on July 17, 2003 regarding the Grievant's termination. The grievance was processed through the parties' contractual grievance procedure. By letter of September 25, 2003, the Union was advised that the grievance had been denied at Step 2. By letter of January 26, 2004, the Union advised the County that it that day filed a Request to Initiate Grievance Arbitration with the Wisconsin Employment Relations Commission. At the arbitration hearing, the County raised a procedural issue as to the timeliness of the Union's request for arbitration.

POSITIONS OF THE PARTIES

County

The County asserts that it had just cause to terminate the Grievant and further that the Union's request for arbitration was untimely within the context of the parties' labor agreement.

As to just cause, the Grievant was aware from the patient's care card, as well as through personal observation and interaction with other staff, that O.A. required an alarm on her gown. On June 23, 2003, the Grievant ultimately left O.A. alone, who was discovered sometime later naked on the floor after having fallen and broken her right hip.

The County asserts that the Grievant has offered several different versions of what occurred. At hearing, the Grievant testified that O.A. took her gown off maybe five times while the Grievant was present and that she replaced it. This is inconsistent with her statement to Hersrud and her statement at the June 26th meeting that she left the resident without a gown. Further, the Grievant testified that "She wasn't going anywhere; she was not in harm's way", inconsistent with her statement in her June 25th report that she advised Everson that the patient needed to be watched. The Grievant also testified that she did not hear any alarm after she left O.A.'s room, which is inconsistent with her statement at the June 26th meeting that several alarms were going off elsewhere and also inconsistent with her statement to Hersrud that she left to continue passing meds. While Everson indicated there may have been one more resident on that floor that had an alarm in addition to O.A. and the resident Everson was treating across the hall, she also indicated that a third alarm was not going off at the time. Thus, Baker did not leave to answer an alarm even though she on at least one occasion claims she did. The Grievant's testimony was also inconsistent about whether she heard O.A. fall. At hearing, she testified she did not hear it, but Hersrud's statement indicates that the Grievant told her she heard the resident fall.

As to the Grievant's handling of O.A. after the fall, Everson testified that in cases like this the RN is to be summoned and that an injury evaluation for a broken hip occurs with the patient laying flat. The Grievant directed transfer of the patient to the commode and then to the bed, and then summoned the nurse. Ultimately, the County was fined for the fall and the transfer thereafter. While the County does not contend that the transfer was part of the decision to terminate the Grievant, it may provide additional independent grounds. Further, the County offers the evidence for the purpose of demonstrating the Grievant's consciousness of guilt with regard to leaving the patient alone before the fall.

The County concludes that whether the Grievant left O.A. with her gown on or off or replaced it five times, several conclusions are inescapable. First, the Grievant knew the resident was at risk of falling and that she required an alarm. It is clear from the Grievant's testimony that the resident was in an agitated state, and if the Grievant's statement that she replaced the gown and alarm five times is to be believed, the Grievant had to know that the patient was at a heightened risk at the time. The Grievant indicated she waited at least five minutes for the CNA to return, but was angry and left the patient alone. Leaving the patient at risk in an obviously compromising position is more than sufficient just cause to support her termination. As a health care worker, the Grievant is charged with protecting the patients, and she clearly did not do so in this case. Whether the patient fell and was injured is not dispositive. The judgment to leave O.A. alone in the circumstance that the Grievant describes is more than sufficient.

The County cites a number of cases of the Labor and Industry Review Commission (LIRC) as finding that simply poor performance can constitute misconduct sufficient to deny unemployment compensation. While those cases involved employees sleeping or nodding off on the job, in this case the Grievant, while not asleep, absented herself from the situation that required her attention. She did not do so to answer an alarm elsewhere, nor did she call for assistance from any other staff who may have been available, but simply walked away, letting whatever was going to happen, happen.

While it is true that having an alarm on would not necessarily prevent the fall, whether actual harm comes to the resident is not the proper consideration. It is the fact that the resident was exposed to the risk of harm as a result of an employee's action that is significant. Citing a decision of the LIRC involving the finding of misconduct based on an employee at a residential facility for the elderly leaving a resident alone for two minutes in a bathtub. The County asserts that in the LIRC cases it has cited, the employees were found ineligible for unemployment compensation because the employee's conduct evinced a willful or blatant disregard of their employer's interest, as is found in deliberate violations or disregard of standards of behavior which the employer has the right to expect of its employee, or in carelessness or negligence of such degree as to be the equivalent of a deliberate violation. Clearly, the Grievant's action here was at a minimum careless, and in substantial disregard of the employer's interest and the employee's duties and obligations to the employer.

With regard to timeliness, the County asserts that it denied the Step 2 grievance on September 25, 2003 and that on October 15, 2003, the Union advised the County it would seek arbitration of this grievance. Thereafter, the Union made application to the Commission on January 26, 2004 for appointment of an arbitrator. Such delay is prejudicial and should lead to the conclusion that the Arbitrator has no jurisdiction. In the alternative, the County asserts that this delay, as well as the delay from rescheduling the hearing from March 19 to April 16 at the Grievant's request, should be considered in the event backpay is awarded.

Union

The Union takes the position that the County did not have just cause to terminate the Grievant. There is no dispute that on June 23, 2003 resident O.A. fell from her bed and broke her hip, and that at the time she was not wearing her gown, and thus did not have her alarm connected. The Homes' Administrator, Lagerfeldt, told the Grievant that the employer was not saying that she caused O.A.'s fall, and stated that even if O.A. had her gown on and the alarm clipped to it, it would not have prevented her from falling and breaking her hip. Thus, the question is whether the decisions made by the Grievant were "intentional omissions" and did she "exercise poor judgment" that left resident O.A. in an "unsafe manner." The Union answers in the negative. CNA Everson's testimony confirms that she and the Grievant were initially present in O.A.'s room and that O.A. was restless and yelling and had removed her gown more than once. Everson testified that after she left the room to attend to another resident, she did not see either Baker or O.A. again until she found O.A. on the floor, and that she did not see Baker leave O.A.'s room and had no idea whether or not O.A. was wearing her gown and alarm when the Grievant left her to attend other residents and complete her med pass. The Grievant's testimony mirrors Everson's on the events that occurred while both she and Everson were in O.A.'s room. The Grievant also testified that when she left O.A.'s room, O.A. had her gown on and was in bed and the alarm connected. Other than the Grievant and Everson, the County offered no other first-hand testimony of the events leading up to O.A.'s fall.

The Grievant's testimony that O.A. was dressed with the alarm attached when she left her room is challenged only by LPN Hersrud, who testified the Grievant had told her during the a.m. report meeting that O.A. had been restless and that when she left O.A.'s room the latter's gown was off. The Grievant denied she told Hersrud the gown was off and believed Hersrud misunderstood her. Hersrud's June 25th written statement makes no mention of the Grievant leaving O.A. without a gown on, and supports the Grievant's statement that she left O.A.'s room to continue the time-sensitive med pass. Hersrud did not witness the incidents that gave rise to the termination. The only person to know whether or not O.A. had on her gown and alarm when she left the room is the Grievant herself, and she testified that O.A. was wearing both.

The Union contends that the Home's investigation was inadequate and incomplete. The minutes taken of the June 26th meeting held for the purpose of terminating the Grievant indicate that the administration conducted an investigation of the event that led to O.A.'s injuries. Lagerfeldt is quoted in those minutes as saying that they had interviewed other people in the unit on the shift at the time, yet at the arbitration hearing, the County offered no testimony other than that of Hersrud and Everson. Lagerfeldt did not testify. Also as important is the fact that no one ever asked the Grievant to give her side of the story. While Johann called the Grievant the next day and informed her that she was suspended and that the Home was conducting an investigation, and then subsequently called to tell her that she needed to come to a meeting on June 26th, she never asked the Grievant to tell her side of the story. Similarly, at the June 26th meeting, Lagerfeldt began by advising the Grievant that a report had been made and they had investigated and that the Grievant was being terminated. At no time was the Grievant asked for her side of the story or to explain what happened on June 23rd from her perspective. The Grievant was simply terminated without being given the opportunity to defend herself.

The standards of just cause have been well established. Most people involved in labor and management disputes rely on Arbitrator Daugherty's decision in ENTERPRISE WIRE CO. (46 LA 359,1966) to establish the seven standards of just cause. Those standards include: "Did the Company, before administering discipline to an employee, make an effort to discover whether the employee did in fact violate or disobey a rule of management?" Daugherty states that an employee has the right to know with reasonable precision the offense with which he is being charged and to defend his behavior. Daugherty also opined that the investigation must normally be made before the employer makes its decision. If the employer fails to do so, it may not be excused on the grounds that the employee will get his day in court through the grievance procedure after the exaction of the discipline.

The Union asserts that Lagerfeldt and Johann both failed to testify at the hearing although they were both available to do so. There is no record of Lagerfeldt and Johann's investigation, beyond the testimony and statements of Hersrud and Everson, and the Union did not have an opportunity to cross-examine Lagerfeldt or Johann, nor the other sources of their investigation. This omission by the County of critical witnesses should not be viewed as simple oversight. "The failure of a party to call as a witness a person who is available to it and who should be in a position to contribute informed testimony may permit the arbitrator to infer that had the witness been called, the testimony added would have been adverse to the position of that party." Elkouri and Ekouri, *How Arbitration Works*, Sixth Edition (p. 381-382).

The Union also notes that the State found no violation in the Grievant's actions. Pursuant to Chapter HFS 14, the Home notified the State of the alleged patient care violation. In response, the State Department of Regulation and Licensing conducted an investigation of

O.A.'s fall. Chapter HFS 13 defines a number of violations, including misconduct, neglect and abuse. Employees of health care facilities found to have violated these rules are placed on a "caregiver misconduct registry" and are not allowed to work providing direct care to residents of health care facilities. The complaint filed against the Grievant was investigated by the Division of Disability and Elder Services, Bureau of Quality Assurance. The screening panel that conducted the review and evaluation of the information determined that the information did not indicate a violation of the Wisconsin Administrative Code or State statutes which regulate the practice of the Grievant's profession, and determined not to take any action based on the complaint. Provided with the evidence of the events leading up to O.A.'s fall and the Grievant's involvement, the State's experts clearly found that the Grievant's conduct was not neglect, misconduct or abuse. The Grievant continues as an LPN able to provide care in nursing homes.

The Union concludes that the County has not demonstrated "poor judgment", nor that O.A. was left in an "unsafe manner." The Grievant left O.A. in her room dressed in her gown with an alarm attached. O.A. has a history of taking off her gown and screaming. When the Grievant left the room, O.A. was safe and dressed and attached to the alarm. The Grievant left to perform time-sensitive medication distribution. Failure to comply with the timelines in that regard is both a State and Federal regulatory violation and a work rule violation. While the termination letter contends that the Grievant left O.A. in a "unsafe manner", Lagerfeld told the Grievant at the meeting that she was not responsible for O.A.'s fall or broken hip and that having the gown on and alarm attached would not have stopped her fall. The termination letter also accused the Grievant of "intentional omissions or intent of caregiver neglect." However, no evidence was introduced to suggest the Grievant omitted anything.

Last, the County raised an issue as to timeliness, but offered no evidence to establish any merit to the claim. The parties did, however, stipulate that hearing had initially been scheduled for March 19 and was rescheduled to April 16, 2004 at the request of the Grievant, and that if backpay is awarded, it would not include the time between the initially-scheduled hearing and the actual hearing date.

The Union requests that the Arbitrator find for the Union and order the County to reinstate the Grievant to her previous position with full back pay and all the rights, privileges and benefits she would have enjoyed had she not been unjustly terminated.

County Reply

The County takes issue with the Union's statement of facts. The Union asserts that the Grievant was not familiar with O.A., however, the Grievant testified at hearing that she knew the resident had previously broken her pelvis. Further, in her nursing notes for June 23rd, she

wrote: "Both legs are outwardly rotated as usual." Someone who claims to be unfamiliar with a patient would not know what "usual" is. The Union also asserts in its facts that the resident removed her gown two or three times while the Grievant and Everson were in the room and once thereafter; however, in her written statement, the Grievant makes no mention of multiple gown removals. She also does not mention waiting for the CNA to return, but at hearing testified that she waited at least five minutes for Everson to return. Further, both Everson's and Hersrud's written statements of June 25, 2003 indicate that the Grievant had told them that she did not put O.A.'s gown back on. Further, according to the minutes of the June 26th meeting with the Union and the administration, the Grievant stated "I left her without a gown but asked an aide to keep an eye on her." Given the Grievant's multiple inconsistent statements and her admissions in three different instances that she left O.A. without a gown and an alarm, the only reasonable finding of fact is that the Grievant in fact left the resident without a gown and an alarm.

Also offered as a fact is the Grievant's assertion that she left O.A. to continue with her medication pass. She makes the statement in her written statement of June 25, 2003, however, the minutes of the June 26th meeting indicates that she stated there were several alarms going off as ostensibly her reason for leaving O.A. without a gown or alarm. She similarly testified at hearing that there were other alarms to respond to. This is inconsistent with her own written statement that she left to continue her med pass. It is also inconsistent with the testimony of Everson that there was only one other alarm on a resident on that floor other than O.A. and the resident Everson was with, and that that third alarm did not go off between the time the Grievant left O.A. and Everson's discovery of O.A.'s injury.

The Union's recitation of facts suggests that the Arbitrator should conclude there was nothing going on with the resident and that it was appropriate to leave O.A. alone and for the Grievant to continue to pass medications, because if she did not do so, she would have violated all sorts of rules and regulations. However, the Grievant testified that she frequently failed to complete her med pass on time and that she had never been disciplined in that regard. Not only is her rationalization of leaving to continue her med pass inconsistent with her other statements about answering alarms, her own experience demonstrates it is an inadequate reason to leave a resident at risk. Further, while the Grievant appears to argue that the resident was not at risk, she testified that she replaced the gown and alarm at least five times and stayed with the resident because she perceived there to be a risk. The Grievant was the team leader on the floor, but she did not summon any help. Rather, she engaged in an "absolute lapse of judgment".

In response to the Union's argument that the standard of just cause was not met, the County asserts that if one resolves the credibility issues based on the evidence, that standard is clearly met. The Grievant's failure to follow policy, the care card and to use good judgment with regard to the resident's safety is the cause for her termination.

The Union also argues that the County's investigation was inadequate and incomplete. However, the Grievant gave a written statement of her version of the facts during the investigation and the balance of the investigation was sufficient to satisfy the Home's Administrator that the Grievant had in fact left the resident without her gown and alarm on. The Grievant made that admission to both Everson and Hersrud and those admissions were relied upon by the administration in deciding to terminate the Grievant. While there is understandably some confusion, it is because the Grievant gave several different versions of the facts at different times. That manufactured confusion, however, does not prevent the conclusion that the Grievant left the resident without a gown or an alarm in place. The Union also argues that various witnesses were not heard from, but nothing prevented the Union from bringing whatever witnesses it wished to hear from. Further, the stipulation to the various exhibits resolved the need to present testimony from some additional witnesses. The County concludes that the investigation was adequate and that the evidence presented at hearing was sufficient to verify that the Grievant left the resident without an alarm gown. That the Grievant realizes it was inappropriate to do so is why she now denies doing it.

The County also asserts that the Grievant's efforts to obscure the facts in that regard include transferring the patient before the proper injury assessment was made and can also be seen in her notations in the incident report. She lists the fall as "probable" rather than "actual", and places a question mark on her assessment concerning the right hip injury. This evidence is a consciousness of guilt with regard to a failure to pay attention to a resident who is obviously in distress. All of the rationalizations offered, even if believed, do not alter the appropriate conclusion that the Grievant failed to follow facility policy with regard to resident safety and failed to use good judgment when faced with an obvious situation that called for her to do other than what she did. All of this evidence was in the hands of the County prior to the termination decision, and is before the Arbitrator. The conclusion is inescapable that there was an adequate investigation and just cause for the Grievant's termination.

The Union argues that the State found no violation. The Wisconsin Administrative Code, Chapter N6, provides the Department of Regulation and Licensing with discretion as it may take action when it deems it appropriate. The Union argues that the State's paper review, without live testimony from any witnesses, is sufficient to exonerate the Grievant, even though it argues at the same time that additional witnesses are absolutely necessary for the Arbitrator to find just cause. The County asserts that issue preclusion cannot be based on a discretionary determination without any evidentiary hearing. If issue preclusion is present, it supports the County's position. The only other forum in which all of the witnesses were heard was the unemployment compensation proceedings. There, an examiner found based on testimony that the Grievant was guilty of misconduct with regard to her employment.

The County concludes that there is more than sufficient evidence upon which to find that the Grievant was terminated for just cause, particularly in light of her self-serving and

numerous inconsistent statements. Coupled with her prior suspension for sleeping on duty, the Grievant has demonstrated that her performance does not meet the standard required of health care workers for the County to protect frail, vulnerable residents of its nursing home.

DISCUSSION

The County first raises an issue as to the timeliness of the request for arbitration. According to the County, the Union notified the County on October 15, 2003 that it intended to seek arbitration of the grievance, but did not do so until January 26, 2004. Article 6 – Grievance Procedure, Sec. 6.02, states in relevant part:

> 6.02 Procedure: Grievances shall be processed in accordance with the procedure outlined herein. All times set forth in the Article, unless otherwise specified, are working days and are exclusive of Saturday, Sunday and any holiday recognized by this Agreement.

The Union was notified the grievance was denied at Step 2 by letter of September 25, 2003. Even assuming the Union received the letter the same day as it was sent, October 15th was within 15 working days and the notice of intent to arbitrate was timely. The parties' agreement does not specify a time limit for filing a request to initiate grievance arbitration with the Commission after notice of intent to arbitrate has been given. Thus, there is no express procedural limitation on the Arbitrator's jurisdiction in that regard in the agreement.

The County also argues that the Union's delay in seeking arbitration was prejudicial and that the Arbitrator's jurisdiction should be precluded on that basis. The County asserts this is the case, but beyond the obvious impact of the delay on a back pay award, offers no evidence to support its assertion. However, the Union also offered no explanation for its delay. The Arbitrator concludes from the foregoing that he has jurisdiction to decide the grievance and that the impact of the delay can be adequately addressed with regard to remedy, if that is necessary.

With regard to the substantive issue, the Grievant was informed at the June 26, 2003 meeting by Home Administrator Lagerfeldt, that she was being terminated because she had left a resident in an "unsafe condition", i.e., without an alarm attached. Lagerfeldt clarified what she meant, stating:

> "I want you to be very clear that we are not saying that you caused the fall and the broken hip. We are saying you did not follow policies of the facility and left your resident in a compromising situation and unfortunately it resulted in a fall. We are not saying having the clip on would have kept her in bed.

Your action was of neglect in not following policy and keeping her safe according to the care plan and facility policy."

The termination letter the Grievant received reiterated the basis for Lagerfeldt's decision to terminate her employment:

> "I have reported to the Bureau of Quality Assurance the circumstances of the incident, investigation findings and my conclusion that your actions, while exercising poor judgment in leaving the resident unattended in an unsafe manner, substantiated that this was an intentional omission or intent of caregiver neglect on your part."

Further clarification was provided in Lagerfeldt's July 21, 2003 response to the grievance:

> Ms. Baker was assigned the night shift and was responsible for the care of a resident who required the use of a bed alarm (decision made by Interdisciplinary Team and is on the care plan). At a point in time the alarm was not reattached to the resident properly. This was an act of neglect by not providing the required service to the resident and not ensuring the resident's safety. This resident consequently fell from bed, sustained injury and was hospitalized.
>
> The federal regulations pertaining to the omission by Ms. Baker are:
>
> > F224 (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibits mistreatment, neglect, and abuse of residents and misappropriation of resident property.
> >
> > F324 (2) Each resident receives adequate supervision and assistance devices to prevent accidents.
>
> Based upon this information Ms. Baker was terminated for just cause.

In sum, the Grievant was terminated for leaving O.A. unattended without an alarm in violation of the resident's care plan and Home policy. The Grievant was not terminated for "abuse" of a resident, but for "neglect". She was also not terminated for her subsequent actions in moving O.A. after she fell.

HFS 13.03(14), Wis. Adm. Code, defines "neglect" as follows:

> **(14)**(a) "Neglect" means an intentional omission or intentional course of conduct by a caregiver or nonclient resident, including but not limited to restraint, isolation or confinement, that is contrary to the entity's policies and procedures, is not part of the client's treatment plan and, through substantial carelessness or negligence, does any of the following:
>
> 1. Causes or could reasonably be expected to cause pain or injury to a client or the death of a client;
>
> 2. Substantially disregards a client's rights under either ch. 50 or 51, Stats., or a caregiver's duties and obligations to a client.
>
> . . .
>
> (b) "Neglect" does not include an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance as the result of inability, incapacity, inadvertency or ordinary negligence in isolated instances, or good faith errors in judgment or discretion.

After O.A. had fallen, the Administrator at the Home had those involved or who had had information regarding what had occurred write up investigation reports as to what occurred or what they saw or heard. Reports were completed by the Grievant and Everson, and by Hersrud, who had spoken with the Grievant about the matter. The Grievant also filed an "incident report" regarding O.A.'s fall and resulting injury. The reports of both Everson and Hersrud indicated that the Grievant had left O.A. with her gown off. Hence, O.A. was left alone and her alarm was not attached when the Grievant left, according to what Everson and Hersrud reported they were told by the Grievant.

Contrary to the Union's claim that the Home's administration did not adequately investigate the matter and never gave the Grievant an opportunity to tell her side of the story, the employees involved, including the Grievant, were told to write down what had occurred. While giving the Grievant the opportunity to elaborate on her report would be the better practice, the Administrator was entitled to rely on those reports and this was the Grievant's opportunity to tell what happened from her perspective. Faced with the reports of Everson and Hersrud, neither of whom had any apparent reason to misrepresent what they had heard from the Grievant, which indicated the Grievant had told them she left O.A. without her gown on, the administration could reasonably conclude that is what happened, regardless of what the Grievant indicated in her report.

While the Grievant now denies she left O.A. without her gown on and alarm unattached, that claim is inconsistent with the Grievant's own statement at the June 26th

meeting with Lagerfeldt. When informed by Lagerfeldt that she was being terminated, the Grievant responded,

> Are you saying I am lying? I left her without a gown but asked an aide to keep an eye on her. We had several alarms going off and residents in positions that they needed assistance.

As the County notes, there are other inconsistencies, as well, in the Grievant's versions of what occurred. In her investigation report, the Grievant stated she left O.A. to give a suppository to another resident, and Hersrud's report indicated that is what she was told. At the June 26th meeting and in her testimony at hearing, the Grievant claimed that another alarm had gone off and that she left to follow up on that alarm. Everson testified she had not heard another alarm. The Grievant testified she did not hear O.A. fall, but Hersrud's report indicates the Grievant told her she heard a "thud" and knew it was O.A. on the floor.

Based upon the credible evidence, i.e., the testimony and reports of Everson and Hersrud, it is concluded that the Grievant left O.A. unattended with her gown and alarm off, contrary to O.A.'s care plan and Home policy, in order to continue passing medications.

The Grievant testified that the Unit Nurse on that unit had complained about her spending too much time on resident care and not completing her medication passes on time; however, she conceded she had never been reprimanded or otherwise disciplined for doing so. While the Home also has a policy that medication passes should be completed in a timely fashion, this is not a viable excuse for the Grievant's actions.

The Grievant's actions leaving O.A. unattended without her alarm attached resulted in the State's citing the Home with a Class B violation. The Union notes that the screening committee of the Department of Regulation and Licensing that reviewed the complaint against the Grievant found that the Grievant's actions did not constitute a violation of State regulations or statutes. However, the decision simply reported the screening committee's determination and provided no rationale or explanation beyond that. While it is not the Arbitrator's role to second guess the Department of Regulation and Licensing's findings, these findings are not dispositive as to whether the County had just cause to terminate the Grievant. The screening committee apparently found that the Grievant's actions did not rise to the level of "neglect", as defined in HFS 13.03(14), Wis. Adm. Code., that would have resulted in the loss of the Grievant's nursing license. However, although Lagerfeldt felt the Grievant's actions would constitute "neglect" at that level, the County is not required to prove neglect on the Grievant's part at such a level as would justify the loss of her license. Nor, as the County asserts, is it required to wait until actual harm results from the actions. It is enough that the Grievant's actions placed the resident at risk of serious injury. Further, although the Grievant evidenced a concern about the residents' well being in general, she did not appear to acknowledge her error in judgment nor to accept responsibility for what occurred with regard to O.A.

While, as Lagerfeldt acknowledged, the Grievant's actions did not cause O.A.'s fall, her actions put O.A at risk of falling, as she was left unattended and no alarm was attached which might have alerted the Grievant or the CNA's that O.A. was attempting to get out of bed, so that they would have had an opportunity to respond in time to prevent her fall. This is a sufficient basis for the decision to terminate the Grievant's employment at the Home. Thus, it is concluded that the Grievant engaged in the conduct alleged, and that such conduct constituted just cause for her termination.

Based upon the foregoing, the evidence, and the arguments of the parties, the Arbitrator issues the following

AWARD

The grievance is denied.

Dated at Madison, Wisconsin, this 28th day of September, 2004.

David E. Shaw /s/
David E. Shaw, Arbitrator

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