BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

**VERNON MANOR EMPLOYEES, LOCAL 1667,
AMERICAN FEDERATION OF STATE,
COUNTY, AND MUNICIPAL EMPLOYEES, AFL-CIO**

and

COUNTY OF VERNON, WISCONSIN

Case 141
No. 64216
MA-12841

Appearances:

Daniel R. Pfeifer, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 18990 Ibsen Road, Sparta, Wisconsin 54656-3755, appearing on behalf of Vernon Manor Employees, Local 1667, American Federation of State, County, and Municipal Employees, AFL-CIO, referred to below as the Union.

Dawn Marie Harris, O'Flaherty Heim Egan, Ltd., Attorneys at Law, U.S. Bank Place, Tenth Floor, 201 Main Street, P.O. Box 1147, LaCrosse, Wisconsin 54601-1147, appearing on behalf of County of Vernon, Wisconsin, referred to below as the County.

ARBITRATION AWARD

The Union and the County are parties to a collective bargaining agreement which was in effect at all times relevant to this proceeding and which provides for the final and binding arbitration of certain disputes. The parties jointly requested the Wisconsin Employment Relations Commission to appoint Richard B. McLaughlin as Arbitrator to resolve a grievance filed on behalf of Teresa Meiners, who is referred to below as the Grievant. Hearing was held on February 16, 2005, in Viroqua, Wisconsin. The hearing was not transcribed. The parties filed briefs and waived the filing of a reply brief by May 2, 2005.

ISSUES

The parties stipulated the following issues:

Did Vernon County violate the collective bargaining agreement by giving the Grievant a three (3) day unpaid suspension and/or by terminating the Grievant's employment with Vernon County?

If so, what is the appropriate remedy?

RELEVANT CONTRACT PROVISIONS

ARTICLE II
Management's Rights

2.01 Subject to the provisions of this Contract and applicable law, the County possesses the right to operate Vernon Manor and all management rights in it. These rights include, but are not necessarily limited to, the following:

. . .

D. To suspend . . . discharge, and take other disciplinary action against employees for just cause . . .

BACKGROUND

The County operates Vernon Manor, a skilled care nursing facility. Nancy Witthoft, the Manor's Administrator, issued the Grievant a three-day suspension on an "Employee Violation Report" form dated July 7, 2004 (references to dates are to 2004, unless otherwise noted), which states the "Type of Violation" thus:

> Family complaints regarding personal health information shared by (the Grievant). Failure to respect confidentiality of medical records. Possible failure to perform duties properly.

The form notes the three-day suspension was without pay and was "pending investigation". Witthoft issued a similar form dated July 12 to document the Grievant's termination. The form states the "Type of Violation" thus:

> Verbal abuse of residents. Improper conduct – abusive & profane language. Failure to report a resident's concern which resulted in neglect of a dental condition.

The July 12 termination reflected the culmination of the investigation noted on the July 7 form. Witthoft directed the investigation after receiving a complaint concerning the discussion of resident care.

Carrie Baumgartner, a Social Worker employed by the Manor, reported the complaint to Witthoft. Baumgartner received a phone call on July 6, from Mrs. Jim Dewey, who stated that the Grievant had improperly relayed confidential medical information concerning the care of her mother-in-law, a Manor resident. Baumgartner's notes regarding the conversation state that Mrs. Dewey based her belief on a phone conversation that the Grievant made to her husband, who asked Mrs. Dewey to "pick up the phone and listen in on the conversation." The notes state:

> (The Grievant) told them that (the resident) had not eaten for three days; the nurses were not doing their job as she was listening to their conversations and knew they were not taking care of (the resident) as she should be cared for here. Mrs. Dewey said that (the Grievant) proceeded to tell them that (the resident) was dehydrated and that they should come in and care for her. She also said that (the Grievant) told them not to tell, as she would be terminated for making the call . . .

Baumgartner's notes state that the conversation occurred "the week of June 21" and that the delay in reporting it reflects that Jim Dewey "was planning on being at Vernon Manor as a student C.N.A." that week "and he did not want that to be uncomfortable for him."

After Baumgartner reported the complaint, Witthoft met with Mr. and Mrs. Dewey on July 7. During the conversation, Jim Dewey relayed concerns regarding the Grievant's conduct with residents, which he had observed while serving the clinical portion of his course to become a Certified Nursing Assistant (CNA) through WWTC. Witthoft then decided to call the meeting which led to the notice of suspension noted above.

The Grievant's Disciplinary Record & Personnel File

The first two items of discipline are dated July 24, 2000. One is an "Employee Violation Report" form documenting a verbal warning to the Grievant for "Suspected abuse of a resident (verbal)". The form notes that on July 21, 2000, dining room staff reported that the Grievant responded to a resident who stated he was not hungry, "You don't need to worry – you won't get much to eat anyway." The Grievant signed the "agree" entry on the "Employee Violation Report Form". The form notes that the Grievant stated that she could not recall making the statement, but "Was apologetic & stated she would watch what is said more carefully."

The second item was recorded on a "Residents' Rights Complaint Form" and documents a verbal warning. Baumgartner and an LPN initiated the form, which notes that CNAs were notified as a group to be careful discussing any medication issues with a resident, who, after being started on antidepressant and new pain medications, was told by a CNA, "You're all doped up on your medication." The form notes that sometime after this notice to the CNAs, the Grievant told the resident that no one could joke with him because they had been "hauled into the office because he told on her."

The Manor issued the Grievant a verbal warning on April 4, 2002 for "Refusal to perform services for a resident." The Grievant signed the "disagree" entry on the "Employee Violation Report Form" adding the following response: "I thought (the resident) could be encouraged to take his own shoes off." Joann Knutson, the Social Worker who documented the complaint, described the incident thus:

> . . . He stated he has had trouble with (the Grievant) at night because she won't help to take off his shoes or socks . . . he can get his shoes off if he sits and kicks them off, but he still cannot get off his socks himself. Resident stated that on three separate occasions he has asked (the Grievant) to take off his shoes and socks and each time she replies "You can take care of that yourself" . . . Writer questioned whether (the Grievant) was rude or made further comments. He stated that no she wasn't rude, and she had done other things for him without any trouble. He would just like to ensure that he can have help with his socks and shoes as he wants his feet to be able to breathe at night . . .

The next disciplinary report in the Grievant's file was for "Failure to respect confidentiality of records", dated May 7, 2002. The Grievant signed the "agree" entry on the "Employee Violation Report Form". In that case, the Grievant discussed with her mother the behavior of a resident. Her mother then attended a luncheon at which she discussed the behavior. The sister of the resident's wife was at the luncheon and complained to Witthoft. Knutson issued the Grievant a verbal warning for the incident. The form indicates a "written warning" would follow "should incident occur again."

The next item of discipline, dated May 21, 2002, documents a verbal warning to the Grievant for lighting a cigarette for a resident, then leaving the resident unsupervised. The Grievant signed the "agree" entry on the "Employee Violation Report Form".

The Grievant's most recent performance evaluation, dated May 20, 2003, was given by Merna Fremstad, who marked the "Exceeds Standards" entry for each of fifteen "Core Evaluation Factors."

The Investigation Following The Suspension

Fremstad, the Manor's Director of Nursing, contacted Rhonda Peterson, the WWTC Instructor who supervised the students during their clinical at the Manor. Fremstad informed Peterson to inquire whether her students had observed any inappropriate behavior while at the Manor. Fremstad did not give Peterson any employee names. Two of the students, Ariel Fortney and Tiffany Forde, responded with written statements. Fremstad and Knutson interviewed them and Jim Dewey.

Knutson's notes of her interview with Jim Dewey read thus:

> He stated that he was in the activity room assisting residents at the noon meal. He recalled that there was a female resident there who was leaning to the side in her wheelchair. He stated that (the Grievant) got up and grabbed this resident under the arms, picked her up, and put her back down. This resident then slid down again. (The Grievant) proceeded to do the same thing again. Mr. Dewey said that (the Grievant) then returned to feeding and began giggling about the incident with another C.N.A. . . .

Forde authored a statement documenting the following concerns:

> . . . I witnessed some behavior that I think was inappropriate. The words "Shut up" were used when talking to the patients. She seemed rough when transporting the patients, especially when going to the bathroom. She talked about the patients like they weren't there even though the resident was sitting right there. She ignored a resident's complaint of pain and instead responded with foul language. She made the comment to me that after a certain age, a person should die so they wouldn't have to be taken care of . . .

Fortney's statement reads thus:

> I witnessed inappropriate language to and around the patient. I heard "shut up" many times to the patient. She seemed to be a little too rough with the patients. Sometimes after she had moved them, they looked as though they were in pain or you could just tell they had been mistreated. Sometimes she would ignore residents requests or complaints and at times would say something rude or inappropriate back to them. She would talk about the residents as if they weren't even in the room. She made comments such as "you should just die when you reach 80, you shouldn't be in a nursing home." (While we were on break) . . .

The Grievant declined to give a written statement until she could be represented by her Union representative. After reviewing the Grievant's personnel file and after receiving reports from Fremstad, Knutson and Baumgartner, Witthoft called the July 12 termination meeting.

The balance of the background is best set forth as an overview of witness testimony.

Ariel Fortney

Fortney, currently a student at Edgewood College, was in the WWTC CNA program in June. After roughly three weeks in the program, she took part in a four-day clinical study at the Manor, working with the Grievant for two or three of those days. The clinical was her first work experience. After the clinical, Peterson asked her to write anything she had seen while at the Manor, which she felt was inappropriate behavior. Fortney authored the statement noted above, and was asked to sign and date it a few days later. She stated she had "some

concern" regarding the Grievant's behavior at the time she observed it, but did not feel it was her duty to report it, and did not do so prior to being asked to author a statement. In response to being questioned about her concern for that behavior, she replied "I guess I am."

Jim Dewey

Dewey appeared in response to a subpoena issued by the County's counsel, and initially declined to answer any questions. Ultimately, he agreed to respond "yes" or "no" to questions put to him, and did expand to some degree on those affirmative or negative responses.

The Manor admitted his mother in May. He is his mother's guardian, and became acquainted with the Grievant through his mother's stay at the Manor. He did not see the Grievant force food on a resident, but observed her "being rough."

On July 6, the Grievant phoned him at home, informing him that she had overheard a conversation in his mother's room, during which his mother's care was discussed. The Grievant understood that she had not eaten in three days, and was proving difficult to feed. She advised him his mother should be out of bed and should be as active as possible. She was not assigned to care for his mother, and he was concerned that she should not be privy to her care decisions or be in her room. She was, he stated, in the "wrong place, wrong time."

He phoned the Manor on July 6, to complain that the Grievant had passed on confidential information regarding his mother. While being interviewed regarding the complaint, he advised Witthoft of the incidents he had observed while in the clinical portion of his CNA training, including the incident in the activity room. He noted that a CNA clinical student had offered to assist the Grievant in bringing the resident upright. He thought the Grievant addressed the resident forcefully, calling the resident by name and telling the resident to sit up straight on their own. He also informed Witthoft that he observed the Grievant raise a female resident under the arms, without a gait belt, and roughly move her from a wheelchair to her bed.

Nancy Witthoft

Witthoft noted that CNA staff are given their care assignments at the start of each shift, and are afforded information from a care plan to the degree necessary for them to provide the care. A CNA would not, as a matter of routine, be given access to a resident's master chart or personal medical information. The Grievant was not assigned to Jim Dewey's mother, but could have overheard information being discussed by others or could have been in her room to respond to a light.

Witthoft viewed Jim Dewey's complaint as a recurrence of the Grievant's talking "out of school." Dewey understood the Grievant to be warning him that his mother was dehydrating and would die if left in bed. The Grievant did not deny this, and Witthoft felt a suspension was necessary to conduct a full investigation, particularly in light of her disciplinary history.

At the first interview with Jim Dewey, he stated he was "a little concerned" with the Grievant, and related his observations during the clinical. Those observations, combined with the other students' statements and the Grievant's past record, set the stage for the July 12 meeting. Witthoft described each incident underlying her concerns, including the Grievant's statement to the effect that death was preferable to extended care at a nursing home. The Grievant either acknowledged or failed to rebut each of the incidents. As the interview progressed, the Grievant became upset, ultimately stating that the Manor treated CNAs badly and that Witthoft exacerbated the problems by denying the Union's request for a wage increase. Witthoft was also concerned because she informed the Grievant upon her suspension not to talk to anyone about the matter, but the Grievant had spoken to other employees.

Witthoft saw no option but termination in light of the Grievant's conduct during the interview. The incidents Witthoft covered during the meeting established patient abuse and multiple violations of residents' rights as well as Manor policy.

Merna Fremstad

Fremstad, with Baumgartner and Knutson, worked as a team to investigate the allegations concerning the Grievant. On July 7, Witthoft confronted the Grievant concerning Dewey's allegations. The Grievant stated that people were putting words in her mouth and that Mrs. Dewey was jealous of her. She admitted calling the Deweys, and did not deny relaying concerns regarding care of a resident. Fremstad contacted Peterson after this interview to determine if the clinical students had observed inappropriate behavior. After learning from Peterson that two students had responded in the affirmative, Fremstad and Knutson interviewed them. After the interviews, they concluded that they had substantial evidence of abuse. Specifically, they concluded the Grievant had told a resident to "sit up . . . you know you can sit up" in a harsh tone of voice; had said "shut up" several times to a resident; had been rough handling residents; and had responded to a resident complaining of a toothache that she had an "ass-ache." The team reported its findings to Witthoft, who called and handled the meeting of July 12. The Grievant knew each allegation, but denied none.

Joann Knutson

Knutson has served the Manor as a Social Worker for more than six years. Her primary role is to serve as a resident advocate and to assure the Manor's level of care. She and Fremstad played no role in the student statements other than to take them. She and Fremstad agreed that the Grievant's conduct manifested abuse. Her comments concerning not wanting to live in a nursing home reflected poorly on her attitude at work. At the July 12 meeting, Witthoft asked the Grievant if she had discussed the basis for suspension with anyone and also asked her about the student statements. The Grievant became angry, stating that the Manor treats CNAs "like dirt", mentioning its failure to grant a wage increase. She acknowledged that she was not aware of any symptoms of rough treatment on any of the residents handled by the Grievant.

The Grievant

The Grievant worked for the Manor from May of 1998 into 1999, then left to work at a hospital. She returned to the Manor later that year, working until her termination in July. She knew Jim Dewey prior to his becoming a CNA. He had visited her farm and each of them had an interest in horses. Dewey's wife once observed them talking at the Grievant's farm and was jealous of her. Jim Dewey had tried to "come on" to her, indicating that he wished to leave his wife. She did phone Jim Dewey concerning a horse, but believed that she discussed his mother with him while he was at her farm. The Grievant told Jim Dewey that if his mother remained bed-ridden, she would develop pneumonia. The Grievant had worked with Dewey's mother and with her room-mate. She had no access to Dewey's mother's chart. The Grievant never spoke with Dewey's mother.

She stated that repositioning a two-hundred pound resident is difficult, and that she may have appeared rough when observed by the students. She denied ever throwing a resident into bed or ever forcing food on a resident. When with the students in the activity room, she did no more than remove the tray from a resident who had clamped his jaw shut to refuse more food. The "toothache" incident involved a resident suffering from dementia, who walks up and down a hallway repeating constantly that the resident has to "pee", wants to sleep, or has a toothache. The resident did this in full view of nurses and CNAs, all of whom treated the complaints as speech patterns rather than as complaints of actual symptoms. None of the observing employees responded to the complaints, but she received discipline for it. She acknowledged that she stated during a break, among employees, that if you were over 80 years old and a vegetable, you would be better off dead. It was her opinion, and was never stated to or in the presence of any resident. She did tell a resident to "shush up", but did so while turning from the resident who was constantly complaining of the need to pee, to sleep or to be suffering from a toothache. She did mention an "ass-ache", but did so under her breath as a joke with the students.

At the meeting of July 12, she was asked if she liked her job. She responded that her complaints were not based on the job, but on the Manor's administration. She acknowledged that she did not testify, during her Unemployment Compensation hearing, that Jim Dewey was "coming on" to her.

Mary Stussy

Stussy has been employed at the Manor since August of 1998. She is an LPN and a Team Leader. She worked with the Grievant. She thought the Grievant "did very good" work, and showed leadership qualities. Stussy trusted her, and thought she was "very good" with male residents. She joked with residents and could charm male residents into cooperating. She never observed the Grievant abuse a resident, had never heard such a complaint and thought she was a very good CNA. She did not observe any of the incidents related by the students, and acknowledged that the use of "shut-up" to a resident is improper. The resident that the Grievant thought weighed two hundred pounds probably weighs one-hundred fifty pounds.

Rhonda Schendel

Schendel has served the Manor as a Charge Nurse for a little over two years. She worked with the Grievant for perhaps a year and one-half. She views the Grievant as a good employee, and has never had any trouble with her. She has never received a resident complaint about the Grievant. The Grievant frequently joked with residents, and got along well with them. She did not observe any of the incidents related by the students and acknowledged that "shut-up" is an inappropriate term to use to a resident. Profanity, which might be permissible with another employee, is improper to use with a resident.

Further facts will be set forth in the **DISCUSSION** section below.

THE PARTIES' POSITIONS

The County's Brief

After a review of the evidence, the County contends that the fundamental issue is whether "the punishment of termination" fits "the crime in this case". The contractual standard is just cause, which the County characterizes as one of "fairness", demanding that "an employer is expected to play fair with an employee by putting her on notice of what is expected, giving her a chance to correct behavior by warning . . . of the consequences of continued wrongdoing, by treating all employees in the same or similar manner, and by giving appropriate discipline".

Here, the Grievant's "inability to maintain resident confidentiality and her repeated verbal abuse of residents" dictates that there was cause for termination. That she was discovered to verbally abuse residents poses the issue of "what is she doing when no one is present?" Her past history "of abusive behavior" and her "outrageous misconduct in front of WWTC students" establish cause. The character witnesses have no impact on this conclusion, since "they were stunned" when informed of her abusive conduct. Even though Jim Dewey "was obviously a difficult witness", his observations are consistent with other students.

A review of the evidence establishes that the County was "a most generous employer" for giving the Grievant "multiple prior disciplinary warnings" regarding her abusive behavior and regarding the inappropriate disclosure of confidential information. The Grievant responded with "continued willful and chronic violations that put the safety of . . . residents at risk." Since no nursing home "should be required to maintain any CNA who is so abusive of residents", the grievance must be denied.

The Union's Brief

The Union contends that the County's case rests on objected-to hearsay, stale evidence and the testimony of an uncooperative and non-responsive witness who "had expressed a personal interest in" the Grievant. More specifically, the Union argues that the Grievant had

no discipline between May 21, 2002 and July 7. As a result, the County has effectively ignored the concepts of progressive discipline entirely by jumping to a suspension, or in part by failing to impose "a written warning and/or suspension." Beyond this, the County's basing a three day suspension and a termination on the same incident "rings of double jeopardy."

The Grievant and Jim Dewey "are in agreement that a conversation occurred" regarding his mother's care. However, there is no reliable evidence that the conversation occurred as alleged by Mrs. Dewey or that the conversation involved confidential information. The Grievant did no more than relay her concerns regarding the resident and she had, in any event, no access to confidential information. Jim Dewey's contact with the Manor was "only to express dissatisfaction" regarding the Grievant's discussion regarding his mother's condition. This concern, however, prompted "the witch hunt". The County sought not information, but accusations from former students, who cannot be considered reliable sources of information on quality of care issues. A detailed examination of those accusations establishes that they rest on no reliable evidence or reflect an overreaction to innocuous statements by the Grievant. If the County can prove cause on this evidence, no employee is safe from termination.

The County has alleged deliberate abuse on the Grievant's part, but the evidence will not support it. The proof shows no harm to a resident and no intent on the Grievant's part to inflict harm. It follows that the grievance should be sustained, and that "the grievant be returned to her former position, be "made whole" and that any references to these incidents be removed from . . . all of the grievant's personnel files."

DISCUSSION

The stipulated issue concerns whether the County had just cause to discharge the Grievant. In my view, unless the parties stipulate otherwise, two elements define just cause. The first is that the County must establish conduct by the Grievant in which it has a disciplinary interest. The second is that the County must establish that the discipline imposed reasonably reflects its disciplinary interest.

The conduct the County asserts a disciplinary interest in is far-ranging, listed in the notice of suspension and termination. The allegations focus generally on physical and verbal abuse of residents and on the improper disclosure of confidential resident information.

The improper disclosure of resident information is unproven. Baumgartner received the initial complaint from Mrs. Dewey, then relayed the matter to Witthoft. Jim Dewey testified that he filed the complaint. There is no evidence the Manor resolved or even considered this ambiguity. As initially reported, the allegation was that the Grievant overheard care information discussed by nurses with access to Dewey's mother's records, combined that with her own observations, and warned the Deweys of an inadequate level of care. Jim Dewey's testimony corroborated this account only while he was being asked leading questions. This was at first necessary because he would not cooperate as a witness with either advocate.

However, when he expanded on his answers, they manifested more muted concerns with why and how the Grievant observed Jim Dewey's mother and why she chose to comment on her observations. Witthoft's characterization of the concerns Jim Dewey voiced was that the Grievant had again spoken "out of school." This confirms the more muted concerns of Jim Dewey's testimony and affords no corroboration of the account relayed by Mrs. Dewey, who did not testify. Significantly, there is no reliable evidence that the Grievant had access to resident information. There is no evidence regarding when she could have overheard direct care-givers discuss confidential information or regarding whom they might be. In sum, the evidence establishes at most that the Grievant offered a gratuitous opinion on the condition of a resident she personally observed.

Even without regard to the Grievant's testimony, the evidence supports no County disciplinary interest in the Grievant's conduct. Review of the Grievant's testimony underscores this conclusion. Whether or not Mrs. Dewey was jealous of the Grievant, her testimony confirms she did nothing more than express her personal opinion, when asked, concerning the condition of a resident she had personally observed.

The County's uncritical reliance on Mrs. Dewey's initial account of a significant allegation of impropriety forms a troublesome background to remaining allegations.

The alleged verbal abuse spans a number of incidents, ranging from the use of a harsh tone to direct a resident to sit up, to the use of profanity, to the use of "shut-up." The evidence supports no more than a conclusion that the first-hand witnesses did not think the Grievant acted toward residents in a fashion that the witness personally deemed appropriate. Fortney and Jim Dewey thought the Grievant spoke in a harsh tone to a resident who was not sitting up and to a resident who was not cooperating while eating. A "harsh" tone of voice that induces, without demeaning, a resident to use their strength can be considered effective. A "harsh" tone of voice spoken to demean a resident can be considered abusive. Even ignoring the Grievant's denial of using a harsh tone, the evidence of abuse is tenuous. The assertion that telling a resident that "you know you can sit up, now sit up" standing alone can establish verbal abuse is unpersuasive. If this is abuse, there is little hope for any care-giver who tries to get a resident to test the limits of their strength. More significantly, there is no reliable evidence from first-hand observers that the Grievant acted abusively. Jim Dewey professed "some concern" for the Grievant's conduct. When asked if she was concerned regarding the behavior, Fortney responded "I guess I am." Forde did not testify, but her statement asserts the Grievant "seemed" rough. None reported the alleged abuse until well after-the-fact and only after being asked to report anything "inappropriate." What emerged was their personal opinion on conduct the Grievant engaged in that they did not personally approve of. This evidence has significance, since their perception affords insight into how a resident could perceive the care. This cannot obscure that the accounts betray less abuse than disagreement among care givers. The allegation of abuse turns less on first-hand accounts than on after-the-fact conclusions drawn by administrators.

The significance of this point should not be understated. The first-hand witnesses expressed the same concern regarding the Grievant's conduct toward residents as with the Grievant's expression, outside the presence of any resident, of a wish to die before needing extended care at a nursing home. The attempt of Manor administration to turn this expression of a personal opinion into the source of disciplinable conduct is unpersuasive, and highlights the risk of equating the personal opinions of the students with abuse.

The Grievant's use of "shut-up" or "ass-ache" is related to this point. According to the Grievant, she said no more than "shush-up" and did so to the students, not to the resident. Similarly, she testified she did not use the term "ass-ache" to a resident, but as a joke to the students. Her testimony was credible. At most, the evidence shows the Grievant acted and spoke in ways that could be perceived as inappropriate. The County can claim a disciplinary interest in this conduct, since the residents could have perceived the statements as the students did. Manor administration cannot be faulted for placing disciplinary risk on the Grievant for an inappropriate statement made in a resident's presence, whether or not made to the resident.

The alleged non-reporting of a patient complaint, unlike the allegations noted above, is unproven. The Grievant's testimony that the complaint of a toothache was heard by many care-givers, and treated by all as a pattern of speech rather than an actual complaint stands unrebutted. The same resident complained of a need to urinate without urinating and of a need to sleep while walking. This is not to say the Grievant cannot be faulted. The County, however, asserts that her conduct was causally related to a delay in treating a dental problem. That assertion is unproven. If considered proven, the County has not demonstrated how the Grievant, alone among the perceiving care-givers, can be held accountable.

Allegations of physical abuse are unproven. The time, place, resident or specific conduct being challenged is impossible to isolate with regard to some of the allegations. It may be that the Grievant failed to use a gait belt while transferring a resident from a wheelchair to bed. There is, however, no specificity in the complaint related by Jim Dewey. More significantly, those complaints made with some specificity afford dubious proof of abuse. Two students thought the Grievant was brusque while feeding one resident and was too forceful in getting another resident to sit upright. The Grievant's testimony was at least as credible as Fortney's and was, in any event, more credible than Jim Dewey's. Whether or not the resident she lifted was one-hundred fifty pounds, the evidence remains the same, indicating a personal difference between the students and the Grievant on the amount of force used. The Grievant testified that she grunted with the effort to move the resident and that the students may have reacted to that. This may or may not be the case. The fact is that the evidence shows no more than a different perception of the force used. That difference is not sufficiently well defined to support a disciplinary interest. Ignoring the failure of the students to report the incidents without prompting, none of the first-hand accounts establishes a difference of opinion manifesting the direct observation of physical abuse.

The second element of the cause analysis demands a determination whether the discipline imposed reasonably reflects the proven level of misconduct. It does not. The

County's proven disciplinary interest involves conflicting perceptions of students and the Grievant on the level of verbal and physical force used by the Grievant in a few matters of routine care. The evidence does not manifest verbal or physical abuse warranting a significant level of discipline. Nor does the evidence establish a disciplinary interest for failure to report a resident care complaint or for communicating confidential health care information.

The County's case for termination turns on "continued willful and chronic violations that put the safety of . . . residents at risk." If this had been proven, termination was the County's only recourse. It has not, however, been proven. This rests in part on the weakness of County evidence. In significant part, however, it rests on the strength of evidence not considered by the County. A significant flaw in the County's evidence lies in its uncritical acceptance of student opinion on specific care behaviors. As discussed above, none manifest a significant statement of abuse. Rather, they document personal disagreement on more subtle care issues. Whatever is said of these accusations, they fall far short of "willful and chronic" misconduct. More significantly, the students' willingness to treat the Grievant's statement of a good faith personal opinion as an indication of abuse is unfounded. That this became part of the termination decision is indefensible. To conclude otherwise sends the disciplinary signal that employees should not hold personal opinions, should not state them, or should misrepresent them. None of these behaviors enhances resident care because the underlying conduct, standing alone, is not a resident care issue. Compounding these concerns is the issue whether at least some of the student complaints were reliable. Jim Dewey's testimony is not a basis upon which termination should be erected. The County cannot be held responsible for his reluctance to testify, but that reluctance manifests the County's decision to treat the initial complaint as a fundamental care issue rather than a complaint that needed to be voiced without regard to its underlying merit. Care issues are inherently stressful. The underlying stress may or may not be a reliable indication of the objective merit of the complaint. Here, Manor administration failed to critically evaluate the objective merit of the complaint. The meeting of July 12 confirms this. The Grievant's recall of the incidents underlying the allegations was taken by Manor administration as an admission of guilt.

This sets the background to the strength of evidence not considered by the County. Primary among that evidence is the Grievant's own testimony. Her account was not meaningfully sought by the County. Her request to have Union representation did not mean the County could not get her view of the facts. Instead, the County decided to get her view at the July 12 meeting, when the termination decision had effectively been made. At that meeting, the County did little more than confront her with the evidence it was about to act upon. The Grievant's frustration, taken by the administration as proof of guilt, was never seriously evaluated as an indication of a person wrongly accused.

More significant is the County's evaluation of the evidence it had. As the Union points out, much of the Grievant's disciplinary history is dated. This point has force, but is less significant than the specifics of that history. The Grievant's responses to the discipline varied with the underlying allegations. She did not uniformly respond "disagree" to the discipline. This indicates willingness to consider the merit of the discipline, not the uniform refusal to

accept responsibility that can typify chronic misconduct. Her "disagree" response to the April 4, 2000 warning is significant against the present record. She disagreed because she thought the resident "could be encouraged to take his own shoes off." This is a defensible care option, providing the resident was not forced to sleep uncomfortably. More significantly, Baumgartner's account of the resident's complaint documents that potential misconduct concerns were Baumgartner's, not the resident's. The resident was doing no more than voicing his disagreement with the care choice. That difference of opinion is not, standing alone, abuse.

The County's evaluation of the disciplinary history shows more a rush to judgment on a potential issue of abuse than a critical evaluation of employee behavior. It is not evident why the Grievant's history of minor discipline was considered evidence of a tendency toward abuse while her positive evaluation was ignored. A similar anomaly is posed regarding her statement of opinion regarding the desirability of extended care at the end of life. The personal opinion was diametrically opposed to the Deweys' portrayal of her conduct toward Jim Dewey's mother's care. That portrayal is of a CNA over-zealous in her conduct toward extended care. It is not evident that Manor administrator's evaluated this anomaly. Rather, they took the personal opinion as an indication of a poor attitude toward work, which they considered a manifestation of a tendency to commit abuse, and took the Deweys' account as definitive proof of a betrayal of resident confidentiality. The sensitivity to potential abuse issues is laudable, but that sensitivity must have a basis in fact to meet the standard of just cause.

The County's failure to consider the opinions of others regarding the Grievant's conduct as an employee poses a similar point. Stussy's and Schendel's views are relevant to this matter. The County argues their testimony is irrelevant character evidence, but the evaluation of her personnel file or of the students' complaints is no different. In each instance, an experienced care-giver attempted to isolate patterns of conduct. Fremstad, Knutson and Witthoft did not witness the conduct for which the Manor discharged the Grievant. Each correctly concluded their professional judgment was relevant to the point. Stussy's and Schendel's professional judgment is no less relevant. In each case, the evaluator attempted to use observed conduct to make a generalization on a course of conduct that cannot often be observed. What is most remarkable to this record is the County's unwillingness to consider any opinion that might have defended the Grievant. This led to an unbalanced view of her course of conduct as an employee.

Against this background, the County has failed to show that termination is a reasonable reflection of its proven disciplinary interest in the Grievant's conduct. At most, the County has demonstrated that the Grievant's sense of humor and statements can be viewed by others as profane and coarse. The County can, with cause, verbally counsel the Grievant not to use profanity in the presence of a resident even if the profanity is not directed to the resident, or to use words that can be perceived as "shut-up" in the presence of a resident.

Because the County has failed to establish just cause to discharge the Grievant, the Award entered below orders it to reinstate the Grievant, to make her whole and to expunge any reference to the termination from her personnel file(s). The County can include in her personnel file(s) a written record of the verbal warning noted above, if it chooses to do so.

AWARD

Vernon County did violate the collective bargaining agreement by giving the Grievant a three (3) day unpaid suspension and by terminating the Grievant's employment with Vernon County.

As the remedy to the County's violation of Section 2.01D, the County shall expunge any reference to the suspension and termination from the Grievant's personnel file(s), and shall make her whole by compensating her for the difference between the wages and benefits she actually earned and the wages and benefits she would have earned but for the suspension and termination. The County may include, if it chooses, in her personnel file(s), written confirmation of a verbal counseling regarding her use of terms, in the presence of residents, that can be perceived as "shut-up" or as profane. To resolve disputes regarding the implementation of this remedy, I will retain jurisdiction over this matter for a period of not less than forty-five days from the date entered below.

Dated at Madison, Wisconsin, this 7th day of June, 2005.

Richard B. McLaughlin /s/
Richard B. McLaughlin, Arbitrator

RBM/gjc
6836