BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

AFSCME, LOCAL 3148

and

SAUK COUNTY

Case 152
No. 63689
MA-12677

(Ruth Volk Termination)

Appearances:

Mr. William Moberly, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 8033 Excelsior Drive, Suite B, Madison, Wisconsin, appearing on behalf of Local 3148.

Mr. Todd Liebman, Corporation Counsel, Sauk County, Sauk County West Square Building, 305 Broadway Street, Baraboo, Wisconsin appearing on behalf of the Sauk County.

ARBITRATION AWARD

AFSCME Local 3148, hereinafter "Union," requested that the Wisconsin Employment Relations Commission provide a panel of five arbitrators from which the parties would select an arbitrator to hear and decide the instant dispute between the Union and Sauk County, hereinafter "County," in accordance with the grievance and arbitration procedures contained in the parties' labor agreement. Lauri A. Millot, of the Commission's staff, was selected to arbitrate the dispute. The hearing was held before the Undersigned on September 27, 2004, in Baraboo, Wisconsin. The hearing was transcribed. The parties submitted post-hearing briefs and reply briefs, the last of which was received on February 14, 2004, at which time the record was closed. Based upon the evidence and arguments of the parties, the Undersigned makes and issues the following Award.

ISSUES

The parties agreed at hearing that there were no procedural issues in dispute and framed the substantive issues as:

Did the Employer have just cause to discharge the Grievant? If not, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

ARTICLE 3 – MANAGEMENT RIGHTS

3.01 The Employer possesses the sole right to manage and operate its affairs in all respects and retains all such rights it possessed prior to this Agreement which are not expressly modified or superseded by this Agreement. Such rights of the Employer to manage its affairs shall be liberally construed and modified only by the express language of this Agreement. Those management rights include, but are not in any way intended to be limited by, the following:

A) To manage, direct, and control the operation of the work force;

. . .

C) To hire, transfer and promote, and to demote, discipline, and discharge employees for just cause;

D) To make, modify and enforce reasonable work rules or regulations and standards of performance applicable to the work force;

E) To evaluate employee performance and to plan and schedule training programs;

. . .

I) To take any action necessary to comply with state or federal requirements applicable to its programs;

. . .

ARTICLE 8 – GRIEVANCE PROCEDURE

. . .

Step 4 If the grievance is still unresolved, either party may within ten (10) days after the reply of the Personnel Committee is received or due, by written notice to the other party, request arbitration. Either party may request the Wisconsin Employment Relations Commission to submit to the parties a panel of five (5) arbitrators from its staff. The parties shall alternately strike names from the panel, the remaining arbitrator shall hear the case. The party striking the first shall be alternated. The decision of the arbitrator shall be final and binding on the parties and the arbitrator shall be requested to issue a decision within ninety (90) days after the conclusion of the testimony and argument. Expenses for the arbitrator's services shall be borne equally by the Employer and the Union.

ARTICLE 9 – SENIORITY

. . .

9.04 Loss of Seniority: Employees shall lose their seniority for any of the following reasons:

1. Discharge for just cause;

. . .

REVELVANT POLICIES

SAUK COUNTY HEALTH CARE CENTER
RESIDENT'S RIGHTS

. . .

13. To be free from mental and physical abuse, and be free from chemical and physical restraints except as authorized in writing by a physician for a physician for a specified and limited period of time and documented in the medical record, except that physical restraints may be used in an emergency when necessary to protect the resident or others from injury or to protect property. The physician shall be notified immediately, and authorization for continued use of the physical restrains shall be secured from a physician within twelve (12) hours. Any use of physical restrains shall be noted in the medical record. "Physical restraint" means any article, device, or garment which is used primarily to modify resident

behavior by interfering with the free movement of the resident and which the resident is unable to remove easily, or confinement in a locked room. Mechanical supports shall not be considered physical restraints.

. . .

SAUK COUNTY HEALTH CARE CENTER
PERSONNEL POLICIES

. . .

DISCIPLINE

The concept of discipline is teaching employees to follow and adhere to reasonable rules necessary to carry on the work we are engaged in. Rules, regulations and expectations set forth by the Sauk County Health Care Center apply only to actions and/or omissions effecting the safe, proper application of common sense that an employer has a reasonable right to expect. As people responsible to our residents and the community, we have an obligation to carry on the work of the Center in a business like, professional manner.

Violation of rules triggers disciplinary action. In some cases the action may be a verbal or written warning. In other cases, the action may be more severe. In all cases, the seriousness of the situation, the employees past record, the circumstances surrounding the infraction and the history of similar incidents will be taken into account.

The Center, operating in a fair, consistent and predictable manner, reserves the right to be the sole and final authority in all disciplinary cases, unless otherwise noted in a separate agreement.

The following are rules, which if violated, will result in disciplinary action. This action may include warning, suspension, or discharge. (This listing is not meant to be all inclusive, but rather representative of reasonable rules, regulations and expectations.)

. . .

11. Employees will not engage in any activity endangering the safety and/or welfare of a resident fellow employee, or visitor.

RESIDENT ABUSE

The Sauk County Health Care Center believes and insists that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Mistreatment, neglect, abuse and misappropriation of resident's property are prohibited.

Definitions:

1. Abuse is any single or repeated act of force, violence, harassment, deprivation, neglect or mental pressure which reasonable [sic] could cause physical pain or injury, mental anguish or fear.

2. Verbal abuse refers to any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or with their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability.

3. Sexual abuse includes but is not limited to sexual harassment, sexual coercion, or sexual assault.

4. Physical abuse includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.

5. Mental abuse includes, but is not limited to humiliation, harassment, threats of punishment or deprivation.

6. Neglect means the failure to provide goods and services necessary to avoid physical harm or mental anguish.

7. Misappropriation of resident's property is any misuse, damage, discarding or theft of a resident's property or money.

Employment

The Sauk County Health Care Center will not employ individuals who have been:

1. Found guilty of abusing, neglecting, or mistreating individuals by a court of law; or

2. Have a finding entered into the State Nurse Aide Registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

> The facility will report all allegations involving mistreatment, neglect, or abuse and misappropriation of resident property to the proper state agencies. Actions by a court of law against an employee which would indicate unfitness for service as a nurse aide or other staff will be reported to the State Nurse Aide Registry or other licensing authorities.
>
> . . .

BACKGROUND AND FACTS

The Grievant, Ruth Volk, was employed by County Health Care Center for 10 years as a Certified Nursing Assistant (C.N.A.) until January 13, 2004, when she was terminated. The Grievant's work assignment at the time of her termination was the P.M. shift on the third floor of the facility in the nursing home dementia unit. The Grievant's supervisor was Deborah Hallweg**,** Nursing Supervisor.

The Grievant had a disciplinary record as a result of an incident that occurred in November of 2002. The Grievant was alleged to have "hurt" a resident's feelings when she told the resident that she was "lazy" for having been incontinent. The Investigation Summary Sheet indicates the action taken as a result of the investigation was "Employee was disciplined re: conduct and required to attend training by supervisor." The Grievant received a "Written Confirmation of a Written Warning" on the basis that she was "not demonstrating expected level of care that is required of a SCHCC staff."

The event-giving rise to the Grievant's termination occurred on January 11, 2004, during the P.M. shift. In addition to the Grievant, C.N.A. Maggie Reilly, Unit Nurse, Lara Rabuck, P.M. Nursing Supervisor Hallweg were working that evening. After serving dinner to the residents, the Grievant went to resident M.S.'s room. The Grievant and M.S., with her walker, traveled from M.S.'s room to an unoccupied room which the parties refer to as either the day room or sitting room. The Grievant assisted M.S. into a comfortable chair in the day room and left, closing the door behind her. The day room door was not locked. After a period of time, M.S. got up from the chair, opened the day room door, moved into the hallway and asked Reilly whether she (resident M.S.) could go back to her room. Reilly assisted M.S. back to her room. The day room is located approximately 25 feet from M.S.'s room. The day room has a door, and does not contain call lights. Call lights are located in M.S.'s room.

Resident M.S.'s case plan indicates she has a diagnosis of dementia, anxiety and depression. M.S. is ambulatory with a walker and is identified as a wanderer. M.S. is at risk for injury/trauma resulting from falls and although she may ambulate with a walker, the identified approaches to address the fall risk include keeping a call light within reach at all times and encouraging M.S. to use a call light before standing.

Jeanne Leeck, Administrator of the County Health Care Center, conducted the investigation for the January 11, 2004 incident. Leeck, a 21 year employee of the facility, previously held the positions of Director of Social Services and as a social worker. Leeck received training on how to conduct investigations in 1999 from the State of Wisconsin's Division of Disability and Elder Services and has completed approximately four to five investigations a week since her training. Leeck's investigation included obtaining statements from Reilly, Hallweg and the Grievant the evening of January 11 and a subsequent telephone call to the Grievant on January 12.

On or about January 13, 2004, the Grievant met with Katie A. Pope, County Personnel Manager, Jane Zuehlke, Director of Nursing, and Kari Olstadt, Union Representative. At no time during the meeting did Pope or Zuehlke ask the Grievant any questions regarding January 11 nor did they provide the Grievant the opportunity to explain what had occurred on January 11. Pope informed the Grievant that the County was terminating her employment and provided her with the following letter:

. . .

> As you are aware, on January 11, 2004, a report of alleged resident abuse was received by this facility. Both policy and regulatory provisions require that such allegations be investigated. The specific actions made by you to resident #5302, may constitute resident abuse. On January 11, 2004, at the time the abuse was reported, you were informed of the allegation(s), and provided with an opportunity for explanation. You were then placed on an employment suspension pending a complete investigation.
>
> A thorough investigation has since commenced. Written statements were obtained from yourself, a witness to the alleged abuse, and from other staff members. As a result of said investigation, the Sauk County Health Care Center has determined your actions meet the definition of resident abuse as defined by Wisconsin State Statutes, JFS Chapter 13:
>
> > HFS 13.03 (1)(a)(1) An act or repeated acts by a caregiver or nonclient resident including but not limited to restrain, isolation or confinement, that when contrary to the entity's policies and procedures, not a part of the client's treatment plan and done intentionally to cause harm, does any of the following:
> > (a). Causes or could reasonably be expected to cause pain or injury to a client or the death of a client, and the act does not constitute self-defense as defined in s. 393.48, Stats.
> > (b). Substantially disregards a client's rights under ch. 50 or 51, Stats., or a caregiver's duties and obligations to a client.

> (c). Causes or could reasonably be expected to cause mental or emotional damage to a client, including harm to the client's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, or fear of harm or death, or a combination of these behaviors. This subdivision does not apply to permissible restraint, isolation or confinement implemented by order of a court or as permitted by statute.

In addition, your actions were in complete opposition of the reasonable and common work standards set forth by The Sauk County Health Care Center, as well as the Center's policy on Resident Rights.

As you are aware, the Sauk County Health Care Center will not tolerate misconduct by any employee and is committed to taking all reasonable measures to ensure client safety and security. In addition the facility will promptly investigate all reports/allegations of client rights violations, abuse, neglect or misappropriation of property, reporting the investigative results to the appropriate agencies in accordance with state and federal laws. This correspondence will also serve as your official notification that this incident will be reported to the Bureau of Quality Assurance (BQA).

Please be advised after a thorough investigation and consideration, your employment is hereby terminated with the Sauk County Health Care Center today, Tuesday, January 13, 2004. Your final paycheck will be mailed to you at the above stated address. Please notify the Personnel Department in writing of any such personal items you may have stored on facility premises; arrangements will be made for any such personal items.

. . .

The letter was signed by Pope and Zuehlke. The Grievant and Olstadt signed indicating that they received a copy of the letter.

The County filed a report with the Bureau of Quality Assurance, Caregiver Regulation and Investigation Section (CRIS) alleging that the Grievant had abused and/or neglected a client on January 11, 2004. The CRIS received the report on January 20, 2004 and informed the County the next day that it would not conduct an investigation "due to the minor effect of the alleged incident."

On January 19, 2004, the Union filed a grievance alleging that the termination was in violation of the just cause provision of the labor agreement. The County denied the grievance at all steps placing it properly before the Arbitrator.

At the arbitration hearing, in addition to the facts recited above, the following testimony was taken:

Ruth Volk, the Grievant, testified that her first contact with M.S. on January 11 was when she served her dinner in her room. M.S. was in her bed. The Grievant asked M.S. if she wanted to get up and go to the dining room for supper. After eating her supper in a chair in her room, M.S. went back to bed. The Grievant then got M.S. up and took her down to the day room. The Grievant assisted M.S. by placing her hand on M.S.'s walker and M.S.'s back. She was not tugging on the walker and she was not pushing M.S. M.S. did not resist or complain about going into the day room. The Grievant assisted M.S. into a comfortable chair in the day room and told her she would back in two minutes. The Grievant left the day room, closed the door, and took the supper trays down to the kitchen. When the Grievant returned to the floor, she went to M.S.'s room and got M.S. ready for bed. The Grievant believes not more than two minutes elapsed between when she left M.S. and when she returned.

The Grievant was called to the office and was first asked if she called M.S. a bitch. The Grievant responded "no." Hallweg also asked the Grievant whether she had closed the door to the day room and the Grievant responded affirmatively. The Grievant was directed by her supervisor to prepare a written statement and after it was complete, was sent home.

Maggie Reilly testified that she is a two-year employee of the County Health Care Center in the capacity of certified nursing assistant. Reilly worked with the Grievant for a little less than two years, had a positive working relationship, and was working on the evening of January 11, 2004. Reilly testified that she observed the Grievant with M.S. that evening in the hallway. Reilly described that "it looked like M.S. was going one way and Ruth wanted her to go another, so it was kind of like pushing against the walker, of who wanted to go which way." Tr. p. 77. Reilly testified that she heard M.S. saying "I want to go to my room, please" and the Grievant telling M.S. that she needed to stay out in the hallway. Reilly testified that she did not see the Grievant push M.S. Reilly believed this was resident abuse because it was "isolating" and not allowing M.S. to do what she wanted. Reilly testified that based on her training and experience, she would not have done what the Grievant had done with M.S.

Later that evening, Reilly was walking down the hallway and M.S. opened the door to the day room and asked if she could go back to her room. Reilly testified that she reported the incident to her supervisor because she knew that it was resident abuse. Reilly concluded that the Grievant put M.S. in the room.

Deborah Hallweg testified that she has been employed by the County Health Care Center for 27 years in a variety of positions, most recently as a registered nurse and P.M. Supervisor. Hallweg was the Grievant's supervisor and they had a pleasant working relationship. Hallweg testified that she received a telephone call at 6:30 p.m. on January 11 from the unit nurse who reported that the Grievant had placed M.S. in the day room with the

door shut. Hallweg then confronted the Grievant, informed her it was uncalled for, asked why she had done it and then called the Administrator. Hallweg testified the Grievant was "very sheepish" and said she was sorry. Hallweg then checked on M.S. and found her to be "fine," "okay" and lying in her bed. Hallweg opined that it was inappropriate for the Grievant to leave M.S. in the day room alone because "its unsafe. And if the resident is at a high risk for falls, they should not be left unattended." Tr. p. 100.

Jeanne Leeck, testified at hearing that she is the Administrator for the County Health Care Center, but that she held the position of Director of Social Services at the time of the January 11 incident. Leeck is a 21-year veteran of the facility and has conducted resident abuse investigations for 15 years. Leeck testified that the Grievant was terminated because she had put resident M.S. in the sitting room, which is isolating and isolation is an example of abuse. Leeck stated that the County determined that it was abuse because the only reason why a resident would be put in a room with the door shut would be to keep them from coming out of the room. Leeck concluded that placement of M.S. in the day room created a high risk for potential harm or injury. Leeck testified that she disagreed with the State's conclusion that abuse/neglect had not occurred.

Kari Olstadt testified that she is a five-year employee of the County Health Care Center working in the occupational therapy department as a therapist. Olstadt is a Union steward and the recording secretary. Olstadt explained that a door is a restraint if the resident is unable to open it, but that it is not a restraint if the resident is capable of opening the door and moving out of the room. Olstadt stated that patients with dementia cannot consistently use call lights and alternately bed alarms and chair alarms are typically used. Olstadt explained that being closed in a room would constitute isolation and further that with a dementia patient, if they are redirected to someplace that they do not want to go, they get highly agitated or cry. Olstadt testified that putting a dementia resident in a room and closing the door violates the standards of care at the facility.

Olstadt was present when the Grievant was informed she was terminated. Olstadt testified that Katie Pope, Human Resources Director, handed the Grievant her letter of termination.

Additional facts, as relevant, will be included in the **DISCUSSION** section.

POSITIONS OF THE PARTIES

The County

The County asserts that the Grievant's discharge was appropriate given the seriousness of the offense and the Grievant's previous incident involving disregard for the standards of care of the nursing home facility and residents' rights.

The County has met its burden of proof and has satisfied the seven standards of just cause posited by Professor Carroll Dougherty. The County met the first test, whether the employee had advance warning of the possible or probable consequences of her conduct, when it disciplined the Grievant in 2002. The Grievant had an extensive training record that included additional training due to her violating the standards of care in 2002. The Grievant signed for and received County Personnel Policies that state that employees will be disciplined should they engage in activity that endangers the safety or welfare of a resident. Additionally, the Grievant received and signed for a copy of the Resident Rights that specifies that residents have the right to exercise freedom of movement.

The rule that the Grievant violated was related to the efficient and safe operation of the County business. The business of the facility is to take care of residents consistent with administrative code and state statute. Wisconsin Adm. Code HFS Section 13.03(14), defines neglect and reads in pertinent part as follows:

> (a) "Neglect" means an intentional omission or intention course of conduct by a care giver … including but not limited to restraining, 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.
>
> 3. Causes or could reasonable be expected to cause mental or emotions damage to a client at is exhibited by anxiety, depression, withdrawal, regression, outward behavior, agitation, fear of harm or death or a combination of these behaviors …

In addition to County rules and policies, the State of Wisconsin imposes codes and statutes. The Grievant's actions in directing M.S. to a room and isolating her in that room meet the statutory definition of neglect. The resident was in danger because she was in a closed room without a call light.

The County conducted a fair and impartial investigation in accordance with the standard procedure involving investigations for resident abuse or neglect before disciplining the Grievant. Leeck testified that she conducted the investigation in the same manner she has conducted all similar investigations at the facility. The Union has not introduced any evidence of bias or discrimination nor has an ill motive been alleged.

Substantial evidence exists proving that the Grievant was guilty as charged. The facts are not in dispute. The Grievant placed Resident M.S. in the day room, closed the door and took the supper trays to the kitchen. As far as whether the Grievant pushed resident M.S.'s

walker, the Grievant's denial is not credible. An inexperienced fellow C.N.A. testified that she observed the Grievant pushing and struggling with resident M.S. and found the behavior to be so inappropriate that she contacted her supervisor. The facts adduced during the investigation are not in dispute and serve as the basis for the County's decision to discipline the Grievant. Four witnesses testified that the Grievant's action of directing resident M.S. to the day room and closing the door violated the standards of care of the Center. Maggie Reilly, a two-year CNA; Deb Hallweg, the nursing supervisor, Jeanne Leeck, Administrator of the Center; and even the Grievant's own witness, Kari Olstadt, testified that the Grievant's actions were just plain wrong.

The County scrupulously followed its procedures and conducted a fair and impartial investigation. There is no dispute as to what occurred. Rather, the only dispute is whether the Grievant's actions were sufficiently serious to warrant termination.

With regard to the degree of discipline administered, the County maintains that the seriousness of the offense and the employee's record of service support the discharge. The action of isolating resident M.S violated state statute and state administrative code as well as the standards of care for the facility. The resident was placed in danger by being in a closed room without access to a call light, especially since the resident has difficulty walking and could have easily fallen. The Grievant has a disciplinary history for violating the standards of care and disregarding the rights of residents. The Grievant should not be in a position that provides patient care.

Finally, arbitral case law supports the County's discharge of the Grievant. In a strikingly similar case, JEFFERSON COUNTY, CASE 118, NO. 63281, MA-12536 (SHAW, 9/04), Arbitrator David Shaw was presented with a C.N.A. who left a resident alone without the ability to utilize a call button in contradiction to the resident's care plan. The County discharged the employee and Arbitrator Shaw upheld the discharge concluding that leaving the resident alone was a violation of the standards of care.

The Union

The Union argues that the County failed to meet the just cause standard when it discharged the Grievant in as much as the conduct for which the Grievant was discharged does not constitute patient abuse and the management at the Health Care Center were derelict and failed to fulfill their obligation to conduct a full and fair investigation prior to making the decision to terminate the Grievant.

The evidence does not support a finding that the Grievant was guilty of patient abuse which is the County's reason for discharge. The State of Wisconsin Caregiver Regulation and Investigation Section reviewed the facts and found that no abuse had occurred. M.S. was not restrained or confined when she was placed in the sitting room. M.S. did not complain about

being placed in the sitting room. M.S. is ambulatory, has the ability to open and close a door and ultimately got up on her own, walked to the door, opened the door and exited the room. M.S. was not injured, upset or harmed.

The only witness who testified regarding the alleged abuse was the County's witness, Maggie Reilly, who has only two years experience as a C.N.A. Reilly's testimony at hearing is inconsistent with her written statement and should not serve as the basis for the Grievant's termination.

The County violated a major component of its responsibility in investigating the alleged incident by failing to interview or allow the Grievant to tell her side of the story prior to making the decision to terminate the Grievant. At no time did any member of the management team ever take the time to sit down with the Grievant and ask her for an explanation. The Union cites Elkouri and Elkouri, How Arbitration Works, 6th Edition, p. 967 (2004), wherein it states "an employee must be given an adequate opportunity to present his or her side of the case before being discharged by the employer."

The Union maintains that the County did not have just cause to terminate the Grievant and the grievance should be sustained.

The County Reply

The County challenges the Union's characterization of the Resident and the event of January 11. The Resident was mobility impaired and a fall risk. The Resident desired to stay in her personal room and believed it was necessary to obtain approval before she left the day room. The Grievant's testimony that she was helping the Resident go for a walk is incredible given the Resident's unwillingness to go for a walk.

The Union's challenge to just cause is without merit. First, the County does not need to substantiate resident abuse in order to terminate the Grievant because the Grievant's action was in violation of the standards of care for the facility. Both the County's witnesses and the Union's witnesses testified that the Grievant's conduct violated the facility standards of care. Even the Grievant stated that she had violated the standards of care. Additionally, the County's personnel policies provide that neglect is a sub category of resident abuse and since the Grievant's conduct constituted neglect, it therefore also met the definition of abuse.

With regard to the Union's belief that the investigation was incompleted because the Grievant was not spoken to, there was no need for the County to interview the Grievant. The Grievant provided an extemporaneous written statement about what happened on the evening the incident occurred. Due process cannot be violated where the Grievant made a statement regarding what was alleged and the Union does not take issue with the facts.

In conclusion, the Grievant violated the standards of care of the County's Health Care Center health care facility and it was the second disciplinary incident within a one year time period. The termination was justified and the grievance should be dismissed.

DISCUSSION

The County has utilized Professor Carroll R. Daugherty's seven test questions to analyze whether the discharge meets the just cause standard. See, ENTERPRISE WIRE CO., 46 LA 359 (DAUGHERTY, 1966). The Union's challenge to just cause similarly addresses two of the seven tests. Although I prefer the standard method of analysis, i.e., whether the employee engaged in the behavior for which she was discipline and if so, whether the level of discipline impose reasonably reflects the County's proven disciplinary interest, I will follow the Union and County's method of addressing this case.

Did the County give to the employee forewarning or foreknowledge of the possible or probable disciplinary consequences of the employee's conduct?

The evidence establishes that the County met this standard. The County provided the Grievant a copy of the County's Resident's Rights and Personnel Policies. The Grievant signed forms indicating that she had received and read each of these documents. The patient rights, including protection from mental and physical abuse and restraint. The Personnel Policies specifically include activity that endangers the safety and welfare of residents as a disciplinary offense and identifies what the facility defines as resident abuse. In addition, the State of Wisconsin has statutory protections against caregiver misconduct. The Grievant had an extensive training record that addressed resident abuse and neglect, including the statutory violations, and she received supplemental training on resident abuse following her written disciplinary warning in 2002.

In addition, I concur with Arbitrator Richard McLaughlin in SHEBOYGAN COUNTY, CASE 342, NO. 61369, MA-11905 (MCLAUGHLIN, 12/01), that patient abuse is an offense that meets the standard noted by Daugherty as, "certain offenses . . . are so serious that any employee . . . may be expected to know already that such conduct is offensive and heavily punishable."

There is no question that the County has met this standard.

Was the County's rule or managerial order reasonably related to (a) the orderly, efficient, and safe operation of its business and (b) the performance that it might properly expect of an employee?

It is the business of the County Health Care Center to provide a safe and caring environment for its residents in compliance with state statutes and administrative code. It is reasonable for the County to establish rules that protect resident rights including freedom from abuse and neglect. The Union has not challenged the business necessity of such a rule. The County has met the second standard.

Did the County, before administering discipline to the employee, make an effort to discover whether the employee did in fact violate or disobey a rule or order of management?

This standard requires that the County not only "make an effort" to ascertain whether the Grievant violated a rule, but also provides that "an employee has the right to know with reasonable precision the offense with which he is being charged and to defend his behavior." See, Arbitrator Daugherty's "Notes," ENTERPRISE WIRE CO. at 363. ID. The County has not met this standard.

There is no question that after Reilly observed what she perceived to be reportable behavior, the County initiated an investigation. The County sought statements from Reilly, the P.M. supervisor and from the Grievant. The County did not obtain a statement from the unit supervisor. When Reilly completed her statement, she knew why she was completing the form and had every opportunity to consider what she would include in the statement and what she would not. That was not the case with the Grievant. When the Grievant completed the form, she did not know what necessitated the completion of a witness statement form. The statement prepared by the Grievant was in response to Hallweg calling her into her office and speaking to her. Hallweg testified that she "firmly talked to her and told her it was uncalled for and asked her why she did it." Tr. p. 91. The fact that the Grievant clarified that she had not sworn at M.S., but may have said that M.S. "looked a little witchy" is evidence that the Grievant was not clear on what allegations were made against her and therefore what she should address in her. Ex. 18E.

The County made a determination on January 11, that the Grievant's actions were so egregious that it was necessary to suspend her immediately. This is a perfectly acceptable response at the initial stage of an investigation when management determines that it must act immediately as a result of the employee's behavior with the caveat that if the employee is innocent, she is reinstated with full back pay. But reliance on the same initial statements without further exploration as the basis for termination is unacceptable.

In order to determine whether the employee is guilty or innocent, the County must conduct an investigation. This required the County to inquire and discover facts and circumstances surrounding the January 11 situation. The evidence establishes that subsequent to the evening of January 11, no further investigation was completed. The Grievant was not informed of the allegations lodged against her, was not interviewed by the County nor was she

given an opportunity to respond to the allegations. The County failed to explore the discrepancies between the three statements. Moreover, it failed to ascertain the events leading up to and giving rise to the alleged incident. Although Leeck telephoned the Grievant between on January 12, the extent to that telephone call was to confirm that the Grievant prepared her statement dated January 11.

Not only did the County fail to fully investigate the allegations reported by Reilly on January 11, it failed to provide the Grievant the opportunity to respond or explain her actions. The County has not met this standard.

Was the County's investigation conducted fairly and objectively?

Leeck completed the County investigation. The process Leeck followed was one that was created and sanctioned by the State of Wisconsin for the purpose of investigating and reporting caregiver misconduct. The State reporting process begins with an event which is investigated to determine whether there is an obligation to report the incident. If the reported event causes the State concern, then the State will further investigate to determine the penalty. It is troublesome in the context of employee discipline for the County to rely on an investigative process that is designed to initiate an investigation. Having said that, there is nothing in the record to indicate that Leeck acted in a manner which jeopardized the fairness or objectivity of the investigation. Given that my concerns with regard to the investigative process are not based on fairness or objectivity and are addressed hereinafter, I find that the County has met this standard.

At the investigation, did the "judge" obtain substantial evidence or proof that the employee was guilty as charged?

The County interprets the placement of the M.S. in the sitting room as "isolating" and finds the Grievant guilty of isolation and inclusively, resident abuse. The record evidence does not support a finding that the Grievant's placement of M.S. in the sitting room constituted "isolation."

Hallweg testified that placing M.S. in the day room was "isolating a resident against her will" and that it was wrong because the resident has the right to not be "closed in a room against her will with the door shut." Tr. p. 98-99. Neither Reilly nor Hallweg's statements, which were prepared at the time of the incident, provide sufficient evidence to support a conclusion that M.S. was being held against her will. The only allegation that allowed the County to conclude that the Grievant was in the day room against her will was Reilly's statement wherein she relayed her observation that she thought the Grievant was pushing M.S. down the hallway arguably enroute to the day room. Whether M.S. went to the day room voluntarily or involuntarily is an essential element to determining whether she was isolated,

and ultimately subject to abuse and the County failed adequately address this issue. Interestingly, Reilly testified at hearing that she heard M.S. tell the Grievant that she wanted to go back to her room. If this testimony is credible, then it is valid evidence to support a conclusion that M.S. was being denied the right to stay in her room. But, this is not information that the County had at its disposal when it made the decision to terminate the Grievant.[1] This further supports and points out the insufficiency of the County's investigation.

The County emphasizes that the fact that Grievant closed the door noting that there was no reason to place her in the day room and shut the door other than to keep her from coming out. That may be true, but the County never inquired of the Grievant, nor any other employee, what the reason may have been for the Grievant to have placed M.S. in the day room. The Grievant's statement indicates she took her to the day room for the purpose of "sit somewhere until I could put and wash her to bed" while she testified at hearing that she did so in order to give M.S. a "change of scenery". Tr. p. 134. While it could be that the Grievant's movement of M.S. was for the Grievant's convenience, the County does not have facts or even inferences at its disposal to reach this conclusion.

As to the issue of M.S.'s safety being endangered, M.S.'s case plan indicates that although she is mobile with a walker, she is also at risk for injury/trauma resulting from falls and it is recommended that she use a call light before attempting to stand. Although there was testimony that due to M.S.'s diagnosis, it was unlikely that she would have utilized a call light if it was available to her, the County is nevertheless obligated to attempt to ensure resident safety. The Grievant's disregard for M.S.'s case plan placed her in danger when she left her in the day room. I am unpersuaded that M.S.'s mobility is a mitigating factor.

There are discrepancies between Reilly and Hallweg's initial statements. Hallweg completed her report based on what she was told by Babeck who was told by Reilly. Hallweg reported her understanding of what occurred to Leeck who directed Hallweg to send the Grievant home. Hallweg's report states that Reilly saw M.S. in the day room, opened the door, let her out and assisted her back to her room while Reilly's report states that M.S. opened the door and inquired as to whether she could return to her room. It was impossible for Reilly to see the Grievant in the sitting room since there is no window. It is more likely that M.S. got up, exited the room and the asked Reilly if she could return to her room. Reilly is more credible simply because she is the only one that was present and observed the

[1] Reilly testified that she was at the other end of the hallway when she viewed the Grievant and M.S. in the hallway. It is improbable that she was within hearing distance of M.S. so as to hear her say that she did not want to go with the Grievant. Moreover, I am not persuaded that Reilly heard M.S. make these statements because I believe if she had, she would have come to M.S.'s aid since she was viewing what she described as M.S. being "pushed" down the hallway against her will.

situation.[2] The manner in which M.S. exited the day room is an important fact in determining whether the Grievant was guilty of abuse/neglect and the County did not ascertain this element.

This is a difficult case. The facts clearly establish that the Grievant was placed in a room, possibly against her will, and by placing her in there, alone, she was potentially in danger. The County maintains that the essential facts are not in dispute and support its decision to terminate. I disagree. The County conducted a perfunctory investigation and then relied on that investigation as the basis to terminate the Grievant. This very well could have been a termination offense, but the County failed to make its case.

The County has not met this standard.

Has the County applied its rules, orders and penalties evenhandedly and without discrimination to all employees?

The Union has not challenged this standard and there is no evidence in the record regarding the County's application of its rules to employees. Lacking an assertion by the Union supported by credible evidence of discrimination, there is no evidence to contradict the County's actions. The County has met this standard.

Was the degree of discipline administered by the County reasonably related to (a) the seriousness of the employee's proven offense and (b) the record of the employee in her service with the County?

The Union challenges both components to this standard. First, it asserts this is not a serious offense and the fact that the State decided to disregard the County filed complaint is evidence of its insignificance. Second, the County did not rely on the Grievant's prior discipline as evidenced by the fact that it was not referenced the letter of discharge and thus, it was not considered.

There is no question that resident abuse is a serious offense. Moreover, it is an offense that does not require an employer follow progressive discipline given that the resident is a defenseless victim. The County has not proven that the Grievant was guilty of statutory resident abuse. In addition to resident abuse, the County's discharge letter indicates the

[2] The fact that M.S. desired and asked permission to go to her room is consistent with her behavioral pattern. M.S.'s case plan indicates that she is to be encouraged to maintain independence and provides an example of explaining to her that she doesn't have to ask permission before using the toilet. Thus, M.S. requests permission to do daily life functions. As such, I am not as concerned about her requesting permission to return to her room. But for this characteristic, it would be reasonable to conclude that M.S. requested permission because she was timid or fearful of returning to her room, thus allowing for the conclusion that someone may have ordered her or directed for her to remain in the day room.

Grievant's termination was based on a violation of common work standards at the Health Care Center and the Resident Rights policy. The record supports a conclusion that the Grievant violated the common work standards of the facility. Every witness, excluding the Grievant, testified that they would not have placed M.S. in the sitting room. I credit Olstadt's testimony in that it was "just common sense" to not do this. Olstadt was a Union witness, is a Union official and represented the Grievant during her termination proceedings. Even in light of this, Olstadt recognized that common work standards were violated.

As to the second part of this standard, the Grievant was discipline in 2002 for a similar offense. Regardless of whether the County's letter specifically indicates that it considered this offense, there is no question from the testimony that it was in the minds of the decision makers when they determined the level of discipline to be imposed.

In conclusion, the County has not met two of the seven Dougherty standards, conceivable the two most important standards. As such, the termination did not meet the just cause standard. Having said that, the Grievant's behavior was less than stellar and she placed a resident in her care in a potentially harmful situation. The record is void of comparative data as it relates to the severity or lack thereof exercised by the County when imposing discipline. Given that extended suspensions are not standard practice, to do so in these circumstances is not an option. I am therefore reducing the termination to a 10-day suspension. The parties are advised that this level of suspension is not to be viewed or utilized as benchmark for future offenses of similarity, but rather is a conclusion reached from a record void of comparative data.

AWARD

1. The County did not have just cause to discharge Ruth Volk for patient abuse.

2. The County had just cause to issue a 10-day suspension to Ruth Volk for violating the common work standards of the facility when she placed resident M.S. in a sitting room on January 11, 2004.

3. The appropriate remedy is to remove all reference to the termination her personnel files and to make Volk whole by paying her all wages and benefits she would have earned, less any amounts she earned or received that she would not have received but for her termination excluding those dates of suspension.

Dated in Rhinelander, Wisconsin, this 23rd day of June, 2005.

Lauri A. Millot /s/
Lauri A. Millot, Arbitrator

LAM/anl
6847.doc