BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

AFSCME LOCAL 310

and

RACINE COUNTY RIDGEWOOD CARE CENTER

Case 213
No. 64881
MA-13043

(Bell Grievance)

Appearances:

Mr. Thomas G. Berger, Wisconsin Council 40, AFSCME, AFL-CIO, P.O. Box 044635 Racine, Wisconsin, appearing on behalf of Local 310.

Mr. Victor J. Long, Long and Halsey Associates, Inc., 8330 Corporate Drive, Racine, Wisconsin, appearing on behalf of Racine County Ridgewood Care Center.

ARBITRATION AWARD

AFSCME Local 310, hereinafter "Union," and Racine County Ridgewood Care Center, hereinafter "County," requested that the Wisconsin Employment Relations Commission provide a panel of arbitrators in order to select an arbitrator to hear and decide the instant dispute 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 19, 2005, in Racine, Wisconsin. The hearing was transcribed. The parties submitted post-hearing briefs, the last of which was received on November 15, 2005, whereupon the record was closed. Based upon the evidence and arguments of the parties, the undersigned makes and issues the following Award.

ISSUES

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

1. Did Racine County have just cause to terminate Eureka Bell?

2. If not, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

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ARTICLE III
MANAGEMENT

3.01 Except as otherwise provided for herein, the management of the operations and the direction of the working forces, including the right to hire and the right to suspend, discipline, or discharge for cause, and the right to transfer, promote or relieve employees from duty because of lack of work or other legitimate reasons, the right to establish and make effective reasonable rules of conduct, and the assignment of employees to a job vested in the County, together with all other functions of management, with the understanding that such rights of management will not be used for the purpose of discrimination against any employee.

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ARTICLE XVII
DISCIPLINE & DISCHARGE

17.01 No employee who has completed his/her probationary period may be disciplined, suspended, or discharged except for just cause. If the employee believes that he/she was disciplined, suspended or discharged without just cause therefore, the case shall be treated as a grievance subject to the grievance and arbitration provisions of the Agreement. In any such case if the arbitrator finds that the disciplinary action was not for just cause, he/she may revoke or modify the discipline or may reinstate the

employee with or without back pay and seniority benefits in his/her discretion.

A Union representative shall be present at the time any employee is given notice of discipline or dismissal.

17.02 All warnings, including verbal warnings, shall be reduced to writing and a copy will be given to the employee and the Union representative.

The County will furnish the Union with written notification of all suspensions which will include the reason for the suspension. Written and verbal warnings, with the exception of those cases involving patient abuse, will be removed from an employee's record after two (2) years. The County recognizes the concept of progressive discipline. Any discharge or disciplinary action may be reviewed by use of the grievance procedure. Suspensions with the exception of those cases involving patient abuse, will be removed from an employee's personnel record after two (2) years if no further discipline (either formal or informal) were given to the employee for any related or non-related incidents.

BACKGROUND AND FACTS

The Grievant, Eureka Bell, was a 14-year employee of the Racine County Ridgewood Care Center at the time of her termination. She held the position of Certified Nursing Assistant for the entire tenure of her employment. The Grievant regularly worked the night shift. Her supervisor was Registered Nurse Azucena Mattie and in her absence, Registered Nurse Bob (LNU).

The Grievant was working the evening of November 21, 2004. The Grievant brought resident J.S. to the television room at approximately 12:30 a.m. where she gave her juice and crackers. The Grievant stayed with J.S. in the television room for a time period. At approximately 2:30 a.m. Mattie observed J.S putting her head down and concluded that J.S. was asleep. Mattie asked the Grievant to "put her to bed" and the Grievant told Mattie that J.S. was not asleep. Mattie did not say anything further to the Grievant and the patient stayed in the television room.

At 3:15 a.m. Mattie went to B Hall to assist a patient in room 122 and the Grievant started doing bed checks in A Hall. Mattie observed J.S. in B Hall near room 116 and the linen cart. Mattie finished in room 122 and went to room 113 in A Hall to distribute medication. On the way to A Hall, Mattie told J.S. to stay in B Hall.

It is unclear from the record whether the Grievant spoke to Mattie in room 113 or in the hallway outside room 113, but at the end of the conversation, Mattie directed the Grievant to locate J.S. and put her to bed. The Grievant explained that Bob, the other RN who works in Mattie's absence, does not do it that way and that he does not put J.S. to bed when she is awake. Mattie characterized the Grievant's comments as "talking back". Mattie informed the Grievant that she was "not Bob" and "insisted that the resident should be put back to bed," told the Grievant that "she meant what she said", and told her that J.S. was in B Hall. The Grievant did not attempt to locate J.S. or put J.S. to bed at this time.

Mattie finished in room 113 at 3:30 a.m. and went to B Hall to administer a treatment to a patient at which time she realized that J.S. was not in B Hall. Mattie instructed the Grievant to look for J.S. After the Grievant, Mattie and another CNA searched for J.S. for approximately one-half hour, Mattie telephoned the charge nurse, informed her J.S. was missing and was directed to call law enforcement. Mattie telephoned the Sheriff's Department at approximately 4 a.m. who responded to the call. The resident was ultimately found behind the B Hall exit door at approximately 4:30 a.m. The alarm for the exit door was not activated.

On November 23rd, John Manning, Nurse Manager for 2 West and Acting Director of Nursing, met with the Grievant, her Union representatives Donna Elam and Barbara Eyman, and Rhonda Zunk, County Nurse Manager to administer discipline. Manning informed the Grievant that she was terminated. After the discipline was administered, Zuck left the meeting room to make copies of the discipline for the Grievant and the Union and in Zuck's absence, the Grievant admitted that she had been insubordinate to Mattie. At no time prior to the administration of the discipline did the County offer the Grievant the opportunity to respond to the allegations which the County relied upon in making its decision to terminate.

The County documentation for the termination identified the nature of the violation as conduct/behavior and performance and detailed the violation in the Employee Discipline Report indicating that:

> On 11-22-04 at 0230 you were instructed to put resident G.S. (sic) to bed as the nurse observed her to be dozing in her w/c. You responded "no". At 0330 you were again instructed to put the resident to bed. At this time you were argumentative stating that the other nurse doesn't do that. Subsequent to this the resident could not be found and the police had to be called. Failure to follow nurses instructions put the health safety and welfare of the resident at risk.

The Union filed a grievance on December 2, 2004 stating that the County had violated the labor agreement, specifically section "17.01 and any or all other articles that apply. Also did not get a pre-termination conference that has been given to many employees in the past."

The County and Union met on December 13, 2004 following which the County prepared a Grievance Response which read as follows:

> **Grievance Issue**
> Eureka was terminated for insubordination, violation of work rules and unacceptable conduct and behavior. The union requests the discipline be reversed as Eureka disputes the facts and objects to the level of the discipline because she was not given a pre-termination conference.
>
> **Union Position**
> Eureka stated that she didn't present any of this information at the time of her termination. She states that John the nurse manager was asking her questions, but she didn't answer because her mind went blank. Eureka states that the nurse Cena came in to work in a bad mood. Eureka states that the nurse asked her to put the patient to bed and that she said OK. That is when she couldn't find the patient and a search ensued. The Sheriff's department was notified that a resident was missing. Eventually the patient was found at the end of a hallway, in the stair well. Bell states that she reported that the patient was found, and the nurse Cena was upset, teary eyed and had already notified the Sheriff's department that a patient was missing. Eureka states that the alarm was not in the activated position on that door as some unknown person had turned it off. At this time Eureka states she did put the patient to bed, after washing her up and dressing her, for the morning. Eureka states that the next day she heard that Cena told the nurse manager about the incident, and that she had been argumentative and refused to do what she was told. Eureka denies this claim and said that she was only trying to give the nurse a suggestion of how to handle the patient, by telling her how another nurse prevents the patient from exiting the unit. Eureka states that Cena was pushed by Rhonda to make more of the incident. Eureka also claims that all those disciplines seem so sudden and close together. Eureka again stated

that the first time the nurse asked her if the patient was sleeping, to which she replied no. The second time the nurse spoke to her she asked her to put the patient to bed, to which Eureka replied yes.

Eureka states that it is the nurses' word against hers.

Management Position:
Barb states that at 2:30 am, Eureka was told to put the patient to bed to, which Eureka said no. At 3:30, the nurse again told Eureka to put the patient to bed. Eureka became argumentative saying that the other nurse doesn't do it that way; the other nurse closes the door. The nurse again instructed Eureka to put the patient to bed. It was at this time that it was learned that the patient was missing. The patient was eventually found unharmed, but she was at significant risk for injury. Barb states that Eureka failed to follow reasonable instruction from a nurse and her immediate supervisor. This action put the patient at risk for injury. Lastly, Barb stated that the disciplines in Eureka's file were not sudden and close together. The fact is that Eureka has had so many disciplines that she has 4 cards on both sides. Barb also noted that most people don't have any cards of disciplines; some don't even have one.

Discussion
A nurse instructed Eureka to do something, not once, but twice. Eureka refused and argued with the nurse before she attempted to put the resident to bed. Unfortunately, the patient was now missing. If the patient would have been put to bed when Eureka was initially instructed to do so, the patient would have not been found inside the stairwell door, and the Sheriffs department would not have to be called and respond.

Eureka states that it is her word against the nurses. I know Eureka. I have been witness to her poor attitude, lack of respect for others – especially her superiors, argumentative nature, and numerous, numerous disciplines.

> Eurekas' (sic) actions were inexcusable and I am grateful that the resident was not harmed as a result of Eureka's insubordination. In order for this system to function, when it comes to patient care, the nurse aides must follow the instructions of the nurses.
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> **Decision**
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> Grievance denied.
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> Frances Petrick RN
> Administrator

The Grievant has an extensive disciplinary record. Between February 27, 2002 and July 31, 2003 the Grievant received three disciplinary infractions for attendance/tardiness issues. During the same time period, she received two disciplinary infractions for performance deficiencies including a written warning on July 27, 2004 for violations of acceptable conduct/behavior and performance after the Grievant exceeded her allotted break time. Additionally, the Grievant received two three-day suspensions on October 6, 2004. The first of these suspensions was for unacceptable attendance record (two full-day absences, five partial absences and 10 tardys in three months) and the second was for conduct/behavior and performance violations which were explained in the Employee Disciplinary Report as:

> On 9-20-04 when writer began reviewing issues relevant to the state's last day of survey you stated "I hope they stay".
>
> During breakfast you were observed sitting in the dining room. When writer asked you to find something to do you responded "what do you want me to do?". (sic) Writer suggested you pick up trays. You stated that they had just been passed. Writer had just picked up a tray from your resident A.B. Additionally, the a.m., nourishments and pitchers were sitting on the counter and could have been put in the refrigerator. You were sitting wasting time when many resident care related tasks could have been done.
>
> In the afternoon you left on your fifteen minute break at 1:40 pm and returned at 2:05 pm. You went directly to the break room where you remained until you left at the

> end of your shift at 2:25 p.m. You exceeded your assigned break time by ten minutes and were again not being productive.

POSITIONS OF THE PARTIES

The Union

The Union first challenges the three-day suspension issued to the Grievant on October 10, 2004 for unacceptable attendance. The discipline was grieved by the Union, progressed to Step 4 and was awaiting hearing when the incident giving rise to the discharge occurred. The County utilized this discipline as a "step in the discipline ladder" and thus it is fair game for the Union to argue its merits.

The County failed to issue the Grievant a clear understandable order, therefore her discharge for not following the instructions of her supervisor must be overturned. The Grievant's supervisor speaks with a strong accent and structures her sentences in a manner different from her co-workers. Mattie testified that she approved the Grievant's request to keep the resident "up" since she was awake. In at least one of those instances, the Grievant cautioned Mattie to watch the resident. When the Grievant was given an understandable order from Mattie to put the resident to bed, she did so. The Grievant has obeyed understandable directions from her supervisor.

The Union asserts that the County has failed to fulfill five of Daugherty's seven tests for just cause. The County has not met tests two, four, five and six and seven therefore, just cause has not been established. Rule two requires that the County issue an order that is reasonably related to the operation of Ridgewood Care Center. Since the Grievant did not refuse to follow an order, test two has not been met.

Tests four and five require that the County complete a fair and impartial investigation that obtains substantial evidence or proof that the employee was guilty as charged. The County failed to meet these tests because the Grievant was not interviewed in the course of the investigation and therefore the investigation was incomplete. Additionally, the County utilized only the supervisor's statement which negates compliance with test five.

Test six reviews the County's action to determine whether rules, orders and penalties are administered evenhandedly and without discrimination. The evidence establishes that residents have been lost and injured at Ridgewood Care Center. None of those employees were discharged. The Union maintains that this discipline is part of

a pattern issued to the Grievant because she is an employee who stands up for herself and the residents in her care. The County has not met test six.

Test seven reviews the degree of discipline administered by the County to determine if it reasonably related to the seriousness of the violation and her prior discipline record. The Grievant's disciplinary history is the result of attendance problems. The County had ample opportunity to evaluate her and alter her behavior or attitude, but did not do so in the last five years of her employment. The County has failed test seven.

The Union requests that the grievance is sustained and the Grievant made whole.

The County

The County maintains that the Grievant was terminated for just cause. The Grievant did not follow the directives of her supervisor and this insubordination led to the disappearance of a resident. The Grievant was directed to put the resident to bed on two occasions. The second time, she was given an order by her supervisor. The Grievant admitted she failed to follow the direction of her supervisor. The Grievant placed the safety of the resident in jeopardy.

The Union's assertion that the Grievant was not provided an opportunity to give her side of the story is erroneous. The County conducted the pre-disciplinary meeting with the Grievant just like it conducts all other disciplinary meetings. The Grievant had the opportunity to present her version of the episode and admitted she was insubordinate.

The Grievant has a significant and extensive disciplinary history with the most recent discipline, a three-day suspension, issued for conduct/behavior and performance deficiencies in October 2004. Three further conduct/behavior and performance disciplinary sanctions were issued to the Grievant including a written warning in July 2004 and two oral warnings in 2003. The Grievant has also been disciplined on four occasions since 2002 for attendance/tardiness. The County followed the steps of progressive discipline when it terminated the Grievant.

The Union did not offer any specific incidents where other residents had been lost and the responsible employee was not disciplined. Lacking any specific instances, the Union's assertion that the Grievant was subject to differential treatment must fail.

Finally, the Grievant is not credible as evidenced by her responses to questions regarding her disciplinary history.

For all of the above reasons, the County requests the Arbitrator deny the grievance and uphold the discharge of the Grievant.

DISCUSSION

The issue is this case is whether the County had just cause to terminate the Grievant. The Union challenges the discipline citing just cause violations and proposes that I follow 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). I prefer to rely on Arbitrator Richard McLaughlin's written enunciation of just cause which he stated in BROWN COUNTY, CASE 655, NO. 60134, MA-11535 (MCLAUGHIN, 3/02). Arbitrator McLaughlin stated in BROWN COUNTY that "first the employer must establish conduct by the Grievant in which it has a disciplinary interest. Second, the employer must establish that the discipline imposed reasonably reflects its interest. This does not state a definitive analysis to be imposed on contracting parties. It does state a skeletal outline of the elements to be addressed, relying on the parties' arguments to flesh out that outline." ID.

The Grievant was terminated for "failure to follow nurses instructions [which] put the health safety and welfare of the resident at risk". The County specifies that the Grievant was given two directives from her supervisor which she failed to follow. It need be noted at this juncture that the Grievant was directed by Mattie on three occasions to put resident J.S. to bed. Both the County and the Union reference two directives in their arguments. For clarity, the two directives that the County references are the first and second while the Union refers to the first and third directives.

Looking to whether the Grievant engaged in the behavior for which she was disciplined, the County concluded that the Grievant failed to follow the direction of her supervisor on two occasions, both times after she was directed to put resident J.S. back to bed. The first instance relied upon by the County occurred somewhere near 2:30 a.m. after the Grievant had observed the resident awake, dressed her and took her to the television room where she gave the resident juice and crackers and watched television with her. At that time, Mattie observed J.S.'s head drop and believing that J.S. was falling asleep, directed the Grievant to take the resident to bed. The Grievant responded to Mattie's direction by stating that the Grievant was not asleep. The fact that the Grievant responded clarifying J.S. was not asleep leads me to conclude that Mattie said more to the Grievant than "put the resident to bed." It is more reasonable from this record to conclude that Mattie's comments were something closer to "the resident is falling asleep in the chair, take her to bed." The County's disciplinary report erroneously concludes that the Grievant responded in the negative to Mattie's direction. Had the County conducted an investigation and allowed the Grievant to

respond to the allegations, this would not have occurred. Ultimately, it is not relevant because Mattie acquiesced to the resident staying in the television room which indicates that the Grievant's suggestion was accepted, her behavior was tolerated and negates any assertion on the County's part that the Grievant disobeyed an order from her supervisor.

As to the second instance relied upon by the County, it is undisputed that the Grievant was given a direction by Mattie to put J.S. to bed. The record establishes that the Grievant responded to Mattie, quite possibly in an argumentative manner, that the part-time nurse who works in Mattie's absence does not put J.S. to bed when she is awake and that he closes doors and allows the Grievant to travel in the hallway. After this exchange, the Grievant did not attempt to locate J.S.[1] The Grievant's actions constitute insubordination and that is a disciplinable offense.

The Union points out that the Grievant's supervisor, Mattie, has a strong accent and structures her sentences in a manner different than most when communicating. As a result of this communication style, the Union argues that the Grievant did not understand the directive and therefore could not have complied. While I concur with the Union's description of Mattie's communication style, this does not absolve the Grievant. The Grievant and Mattie had a working relationship. Had it been the case that the Grievant did not understand Mattie, then it was her obligation to request clarification. That did not occur. The evidence establishes that the Grievant failed to follow her supervisor's directive.

Moving to the penalty imposed, the County terminated the Grievant based on two instances of insubordination and her prior record. As addressed above, the first identified violation is factually inaccurate while the second instance of insubordination is supported by the record. The question is whether there are sufficient mitigating factors so as to conclude that a lesser discipline is appropriate given this record. I conclude that there are.

The County maintains that the Grievant's failure to respond to her supervisor's directive placed "health safety and welfare of the resident at risk." Although it may be true that had the Grievant immediately responded to Mattie's directive and gone to locate the Grievant so as to put her to bed, then J.S. would never have been lost. It is also possible that when the Grievant immediately responded to Mattie's directive, she would have been unable to locate J.S. The Grievant was working in A hall prior to

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[1] The County's grievance response indicates that one hour elapsed between the second and third directive. This is inconsistent with Mattie's written report prepared November 22, 2004. Had the County completed an investigation of this incident, it would have learned that no more than 15 minutes elapsed.

Mattie telling her to take J.S. to bed. Mattie had seen J.S. near the linen cart in B hall before Mattie went into a B hall room to assist a patient. Mattie then went to an A hall room where the Grievant found her and the directive was given. Mattie was the last staff member, according to this record, to see J.S. in B hall. It is only conjecture on the County's part to conclude that had the Grievant responded when directed, then J.S. would not have been lost. Moreover, such a conclusion fails to recognize that the failure of the alarm system to be properly activated was a contributing factor to the ultimate disappearance of the patient.

As to the Grievant's discipline record, it is far-reaching and includes multiple types of violations. Let me first address the overall record and then I will focus on the October 6, 2004 discipline.

The Grievant was disciplined nine times since 2000 for attendance issues. The Grievant was asked during her direct examination whether she had an attendance problem and she responded "not to my knowledge. …" tr. 37. There is no question that the Grievant does not recognize the importance of timeliness, especially in a 24/7 facility, where her tardiness or failure to show for work impacts patient care and imposes a hardship on her co-workers. The discipline was issued consistent with the Section 17.02 progressive discipline model including an oral warning, a written warning and a three-day suspension. But, the violations that serve as the basis for her termination are not attendance related. Moreover, all violations (verbal and written) that precede November 2002, are outdated per the parties' labor agreement.

With regard to the conduct/performance/behavior violations in her disciplinary history, these are of greater concern for multiple reasons. The Grievant was disciplined in 2003 for two very specific performance deficiencies; failure to complete inservice hours and failure to properly transfer a resident. These are safety concerns and are valid disciplines, but not related to the offense giving rise to the discharge.

The remaining two performance/behavior disciplinary infractions are both timely and relate to the insubordination issue contained in the discharge. The Grievant received a verbal warning on July 31, 2003 for an excessive break and her interactions with supervision and a resident. The expected improvement identified by the County included "..you will react and maintain a professional demener (sic), to including onging (sic) interactions with the resident and visitors. Any problems you may have with another staff member will be discussed privately." Ex. 10.

The second discipline was issued on July 27, 2004 again for an excessive break and for her behavior and attitude with supervision. The written warning informed the Grievant that she was expected to improve by adhering to the 15 minute break and "…maintain a professional attitude regarding facility issues, displaying support for the facility. You

will remain productive during your work hours. Improve your performance and attitude immediately." Ex. 8.

With regard to the October 6, 2004 disciplines, these are suspicious for numerous reasons. First, why were two three-day suspensions issued at the same time? Second, why was the grievance processing interrupted? Third, was the performance/behavior discipline issued for the reasons cited in the report or because of the Grievant's comments regarding the State's presence at the facility. If the underlying facts to this grievance had been substantiated, these questions would be more relevant for purposes of this arbitration.[2]

The next mitigating factor is the County's failure to provide the Grievant an opportunity to provide her side of the story. Integral to basic notions of fairness and industrial due process is the expectation that an employee will be given an adequate opportunity to present his or her side of the case before discharge. Elkouri & Elkouri, How Arbitration Works, 6th ed. (2002) p. 967. The Grievant did not admit to insubordination in the context of a disciplinary or pre-disciplinary meeting. The record establishes that the Grievant made her admission after she was informed of her termination and County personnel were outside the meeting room making a copy of the formal discipline notice to provide to the Grievant. Had the County conducted an investigation and the Grievant admitted during that process that she had been insubordinate, then her admission would be of greater significance. Because of the County's failure to investigate, the disciplinary notice contained numerous deficiencies including factual inaccuracies, unsubstantiated conjectures, personal opinions, and relevant factual omissions. These deficiencies would likely have been identified had the County conducted an investigation and offered the Grievant the opportunity to respond to the allegations.

In conclusion, the issue in this case was whether there was just cause to terminate the Grievant. There was not. The evidence does not support a finding that the Grievant was insubordinate when RN Mattie requested the first time that she take the resident to bed, but there is sufficient evidence to conclude that the Grievant was insubordinate when then she failed to comply with Mattie's second directive. Having found that one of the two basis for which the County discharged the Grievant is unsubstantiated coupled with the County's failure to investigate the November 22, 2004 incident and to afford the Grievant the opportunity to respond to the allegations that the County utilized to support her discharge, the penalty of discharge was excessive.

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[2] The validity of the October 6 disciplines are not before me. The discipline was issued and stands valid as of this date.

There is no evidence in the record to indicate what has been established as the next level of progressive discipline. As such, this award should not be viewed or relied upon to set a future disciplinary standard.

AWARD

1. No, Racine County did not have just cause to terminate Eureka Bell.

2. The County had just cause to issue a ten (10) day suspension to Eureka Bell for violating performance and conduct/behavior standards of the facility when she failed to comply with her supervisor's directive.

3. The appropriate remedy is to remove all reference to the termination in her personnel files and to make Bell 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 20th day of February, 2006.

Lauri A. Millot /s/
Lauri A. Millot

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