BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

COLUMBIA COUNTY (HEALTH CARE CENTER)

and

AFSCME LOCAL 2698,
Affiliated With COUNCIL 40, AFSCME, AFL-CIO

Case 249
No. 65545
MA-13244

(Wess Grievance)

Appearances:

Mr. Joseph Ruf III, Esq., Corporation Counsel and Human Resources Director, Columbia County, 120 W. Conant St., P.O. Box 63, Portage, Wisconsin 53901, on behalf of the County.

Mr. David White, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 8033 Excelsior Drive, Madison, Wisconsin 53717-1903, on behalf of the Grievant.

ARBITRATION AWARD

According to the terms of the 2004-05 labor agreement between the captioned parties, the WERC designated Staff Arbitrator Sharon A. Gallagher to hear and resolve a dispute between them concerning whether there was just cause for the discharge of CNA Sara Wess. Hearing in the matter was originally scheduled for June 16, 2006, but postponed to and heard on July 19, 2006. A transcript of the proceedings was taken and received by the Arbitrator on July 27, 2006. Thereafter, pursuant to their agreement on July 19, 2006, the parties postmarked initial briefs by September 5, 2006, which were received by the Arbitrator on September 6, 2006; and they agreed to reserve the right to file reply briefs postmarked by September 19, 2006, which the Arbitrator received by September 20, 2006, whereupon the record was closed.

ISSUES:

The parties stipulated that the following issues would be decided by the Arbitrator herein:

Did the Employer have just cause to terminate the Grievant?

1) If not, what is the appropriate remedy?

RELEVANT CONTRACT PROVISIONS:

ARTICLE 2 – MANAGEMENT RIGHTS

2.01 The County possesses the sole right to operate County government and all management rights repose in it, subject only to the provisions of this contact [sic] and applicable law. These rights include, but are not limited to the following:

A) To direct all operations of the Health Care Center;

B) To establish reasonable work rules and schedules of work;

C) To hire, promote, transfer, schedule and assign employees to positions within the Health Care Center;

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

E) To relieve employees from their duties because of lack of work or any other legitimate reasons;

F) To maintain efficiency of County government operations;

G) To take whatever action is necessary to comply with State or Federal law;

H) To introduce new or terminate existing methods or facilities;

I) To change existing methods or facilities;

J) To determine the kinds and amounts of services to be performed as pertains to County government operations; and the number and kinds of classifications to perform such services;

K) To contract out for goods or services;

L) To determine the methods, means and personnel by which County operations are to be conducted;

M) To take whatever action is necessary to carry out the functions of the Health Care Center in situations of emergency.

. . .

ARTICLE 5 – SENIORITY RIGHTS

. . .

5.13 Termination of Seniority: The earned seniority of any employee shall terminate when either of the following are applicable:

a) An employee leaves the job and states that he/she is terminating employment;

b) An employee is discharged for just cause.

BACKGROUND

The County operates a 124-bed Health Care Center (Center) at Wyocena, Wisconsin, 24 hours per day, seven days per week. The Center is divided into five wings or "neighborhoods" which house residents who need various levels of care—from being able to perform their own "activities of daily living" (ADLs) to being entirely dependent upon Center staff for all their ADLs and care. One of the Center's wings/neighborhoods (Birch) houses Alzheimer's and dementia residents who must be watched over by a staff member at all times while they are up and out of bed during the day in an area known as "the porch." Approximately two to four CNA's and one licensed nurse are assigned to work each shift on each wing of the Center.

Some residents are not generally ambulatory; they are incapable of getting in and out of bed and of getting to the bathroom without assistance. Moving or lifting such residents from their beds to their wheelchairs or from their wheelchairs to the bathroom or a portable commode requires two employees unless an "EZ-Stand" (EZS) is used which then allows one CNA/nurse to move/lift the resident alone. The manual for the EZS describes its uses as follows:

> The electric EZ-Stand was designed specifically to facilitate ease in toileting and changing of briefs. It was developed in response to studies which indicate that the majority of injuries to nurses aides occur while transferring patients from the toilet to a wheelchair. Using the EZ-Stand eliminates this exposure. In most cases, one person can safely and comfortably toilet or change the briefs of the patient.
>
> Patients are raised and lowered quickly and smoothly which adds to their comfort and security. The EZ-Stand allows patients to stand securely, which increases circulation, bone density and muscle tone. For the EZ-Stand to work most effectively, patients should be able to bear some weight.
>
> The EZ-Stand can also be used for transfers from chair, wheelchair or bed and as a walker.
>
> The EZ-Stand harness was designed to maximize the comfort and safety of the patient. It is quick and easy to apply. The harness has a handle on the back to help the staff person correctly position the patient.

. . .

CNA's and other nursing staff are trained in the use of the EZS at the beginning of their employment and EZS procedures are periodically reviewed with all Nursing Department staff at regularly held nurses' meetings and at report meetings held at the start of daily shifts.

In August of 2006, Director of Nursing Janelle Zacho directed that all nurses, including CNA's, be given the following information regarding a change in Center policy concerning the use of EZ-Stands:

> **Attention Nurses:**
>
> This past weekend, there was an incident with one of our residents and the use of an EZ stand. During this incident the resident ended up with the strap of the EZ stand around his neck. This could have been a horrible tragedy. EZ stands were discussed approximately 9 months ago in nurses meeting. At that time it was decided that the nurses would determine who was safe to be left unattended on an EZ stand. In light of this incident it is apparent that no one is completely safe to be left unattended. Therefore, please inform your CNAs that **no one** is to be left alone on an EZ stand. Any one who does so will be disciplined. The nurses will be held accountable to enforce this. Any nurses not enforcing this will also receive discipline. Any questions, please see one of the nurse managers.

. . .

The above memo was also posted at the nurses' stations on each wing/neighborhood of the Center and it was read to nursing staff at report meetings and discussed (at the start of their shifts) on or about August 6, 2001. [1]

Grievant Sara Wess was hired on July 11, 2001 as a full-time third shift (nights) at the Center. After her hire, Wess completed the necessary six-week training course to become a Certified Nursing Assistant (CNA). Wess received two overall satisfactory evaluations on July 29, 2003 and June 23, 2004. On the former evaluation, Wess was rated as having met all standards except attendance; on the latter evaluation, Wess was rated as having met all standards in all categories.

One day after her second evaluation, on June 24, 2004, a document was issued from Nurse Manager Telvick asking all nursing staff to sign and date that the document they had read: the Care Plan for female Alzheimer's resident J.R.[2] Wess signed J.R.'s Care Plan on July 13, 2004. J.R.'s Care Plan indicated that she had to be transferred by two aides or by one aide using an "EZ-Stand" and the Care Plan twice stated that J.R. was a "*FALL RISK.*"

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1 Wess stated that although she was hired prior to August 6, 2001, she never saw the above-quoted memo posted at the Center.

2 The resident's initials are being used in order to protect her identity from disclosure.

J.R.'s Care Plan also stated that she should use a portable commode at her bedside, not the bathroom toilet and that a goal for J.R. was that she should "remain restraint free" and "free of falls."

Wess' History of Discipline:

Wess undisputably received a verbal warning (March 19, 2004), a writing warning (June 1, 2004), and a one-day suspension (November 17, 2004) prior to her March 19, 2005 discharge. It is also undisputed that Wess filed no grievances or written objections regarding these two warnings and her suspension, and she did not offer Zacho the mitigating explanations for her conduct at the time the disciplinary actions were taken against her that Wess testified to at length herein. As will be discussed *infra*, this Arbitrator has disregarded Wess' testimony on these points as she failed to grieve or otherwise object to these actions by the Center and because the Undersigned has credited Zacho over Wess herein.

In addition, DON Zacho's testimony has been credited herein regarding these incidents and her past practices regarding the manner in which she disciplined employees at the Center. Regarding the latter point, only Wess contested Zacho's disciplinary practices, although the Union called three other unit employee witnesses, including Morse who admitted that Zacho issued her a warning for leaving a resident unattended in an EZS sometime during the past five years. Furthermore, Zacho's testimony was credited over Wess for the reasons more fully discussed, *infra*.

Therefore, the facts concerning Wess' prior disciplinary record are as follows. On March 19, 2004 Wess received a verbal warning from DON Zacho which had been filled out by Nursing Manager Telvick; when Zacho met with Wess regarding the warning, Zacho read and gave Wess the following:

. . .

> **DESCRIPTION OF INCIDENT: (Date, Time, Place, Witnesses, Etc.)**
> Left unit unattended while scheduled peer in another room attending to needs. Was told by peer that she was leaving the unit & both S.W. & A.C. were present.
>
> **RECOMMENDED CORRECTIVE ACTION: (NOTE APPLICABLE WORK RULES, POLICIES, ETC.)**
> Leaving residents unattended on Birch special care unit is unsafe. One staff will remain on unit at all times when unassigned to unit or when scheduled.

. . .

On or about June 1, 2004, LPN Baldwin wrote up Wess for the conduct described below and, as was her practice, DON Zacho met with Baldwin and the resident's spouse regarding the facts contained in the document; Zacho then reviewed Wess' disciplinary record and decided a written warning should issue. Zacho then met with Wess and read her the

written warning, which read as follows:

. . .

DESCRIPTION OF INCIDENT: (Date, Time, Place, Witnesses, Etc.)
6-1-04 1015 Rm 404B. Spouse of resident found res. in bed (which is usual routine) but saw urine soaked undergarment & all bottom liners urine soaked. Writer questioned Sara when the last check was done – had not done res. check error during this shift.

RECOMMENDED CORRECTIVE ACTION: (NOTE APPLICABLE WORK RULES, POLICIES, ETC.)
Residents need to be checked & changed Q2 & PRN[3]

. . .

Wess told Zacho at their meeting that she had been busy and she knew she was supposed to assist that resident but she just "didn't get around to it" (Tr. 27).

Finally, employing her normal practices regarding discipline, Zacho handed Wess the following letter in person on November 17, 2004, in which she suspended Wess for one day, as follows:

. . .

On November 16, 2004, you were observed eating chicken and doing a "word search" book on the Birch Porch, it was before 8 a.m. It was not your break time, you were assigned to the other end and resident cares were not complete on either end of the birch unit. This behavior is unacceptable. Your priority at 8 a.m. is to complete resident cares and assist residents to the dining room for their breakfast.

This is not the 1st time that you have failed to make the residents your first priority and failed to be responsible for your job duties. On 3/19/04 you received an oral reprimand, on 06/01/2004 you received a written reprimand. For your repeated irresponsible behavior you are receiving a one-day suspension without pay. Your suspension day will be on November 30, 2004.

If you feel this discipline is unjust you may file a grievance according to the contract between AFSCME local 2698 and Columbia Health Care Center.

. . .

FACTS

There is no real dispute between the parties regarding what occurred on March 18, 2004 concerning J.R.'s care. It is also undisputed that Wess was responsible for J.R.'s care that day and Wess admitted herein leaving J.R. unattended in the "EZ Stand" without drawing

3 "Q2" means every two hours; "PRN" means as need.

her privacy curtain. Wess' notice of termination reads as follows:

> **Date of Incident:** 03/18/2005
>
> **Summary:** You left resident J.R. (on Birch Blvd.) sitting on the commode up against her closet door. The EZ stand sling was still around her and her arms were suspended in the air. This resident can not be left alone on a commode, nor should she be left connected to the EZ Stand without staff present. In addition you made no effort to protect her privacy. Her roommate was sitting about 4 feet away looking right at her. This was a direct violation of her rights to privacy, dignity, safety, and freedom from restraint. Your position as a C.N.A. is being terminated effective today 3/24/2005.

POSITIONS OF PARTIES

The County

The County argued that its discharge of Wess met all seven of Arbitrator Daugherty's standards in ENTERPRISE WIRE CO., 46 LA 359 (1966), and was therefore reasonable and should be sustained. In this regard, the County noted that Wess was well aware – by common sense as well as through her CNA training and through an August, 2001 memo-that Center residents should never be left unattended in an EZ Stand (EZS); that CNA's who testified herein stated they knew that leaving a resident unattended in an EZS was a violation of Center Rules/Policies. Although Wess asserted she did not recall attending a CNA meeting on the rule discussed at the meeting that residents must never be left unattended in an EZS, she admitted she had heard about the August, 2001 incident where a resident almost strangled after being left unattended in an EZS. In the County's view, as Wess had received three prior progressive disciplinary actions for neglecting residents' needs prior to March 18, 2005, she knew she was subject to termination for her actions toward J.R. on March 18, 2005.

In addition, the Center urged that its rule prohibiting leaving residents unattended in EZS's is reasonably related to the safe and efficient operation of the Center, given the delicate/vulnerable nature of Alzheimer's residents. Furthermore, Zacho's investigation of Wess' conduct was thorough, fair and objective and it clearly showed that Wess violated the EZS rule. The County noted that even though it was Zacho who found J.R. on March 18, 2004 attached to the EZS unattended and without her privacy curtain drawn, Zacho conducted a full investigation of Wess' conduct, including talking to Wess who admitted leaving J.R. exposed and unattended in the EZS.

Zacho then reviewed Wess' disciplinary record before deciding (one week later) to discharge Wess. In discharging Wess, the Center asserted that Zacho applied Center Rules/Policies without discrimination, noting that the March 18, 2005 incident involving J.R. was Wess' fourth incident of patient neglect within a one year period and that Wess had not contested/grieved the discipline she had received for the first three incidents. The County denied singling out Wess, urging that Wess' CNA training and Zacho's prior discipline of Wess showed that Wess not only possessed the skills to be a good CNA she had been treated fairly and given every opportunity (through Zacho's progressive discipline) to succeed but had

failed to do so.

The County argued that discharge was the appropriate penalty in this case as it was in line with prior progressive discipline for similar past misconduct and it was reasonably related to the seriousness of the offense Wess committed. In addition, the County urged the Arbitrator to disregard Wess' explanations (as incredible) for her past misconduct which she never raised at the time she was disciplined and claimed to recall more clearly at the July 19, 2006 hearing herein than at the time of the events involved.

The County also noted that Union Witness Bennett contradicted Wess when she stated that she, not Wess, removed J.R. from the EZS on March 18, 2005. In this case, the County urged that the evidence showed that Wess had read J.R.'s Care Plan and decided not to follow it. The County therefore urged the Arbitrator to deny and dismiss the grievance in its entirety.

The Union:

The Union asserted that the County failed to meet its burden of proof that it had just cause to discharge Sara Wess. In this regard, the Union argued that the EZS manual "suggests a greater role in toileting" than Zacho's testimony indicated. The Union also implied that Zacho must have "lied" about what actions she took after finding J.R. in her room on the commode in the EZS with her arms elevated.

For example, the Union pointed to the testimony of Susan Bennett, the CNA who cared for J.R. just after the March 18, 2005 incident. Bennett stated herein that Zacho came next door to ask Bennett to assist J.R. and that when she entered J.R.'s room J.R.'s arms were not up in the air. The Union noted that both Bennett and CNA Morse confirmed that it was not unusual to leave residents in the EZS and some of the Center nurses knew CNA's did this and they took no disciplinary action. Bennett stated that it was only after Wess' discharge that the County emphasized its Policy against leaving residents unattended in EZS's.

Furthermore, the Union argued that Zacho's testimony herein that Wess attended a CNA meeting at which the Center's EZS Policy was discussed was incredible because 1) both Wess and Morse denied ever questioning Zacho regarding the Policy; and 2) neither Wess nor Morse recalled attending such a meeting regarding the Policy. In these circumstances, the Union urged that the evidence showed leaving residents unattended in the EZS was not uncommon, that such actions were taken by other CNA's and no discipline was given to them and that Wess did not know and could not have reasonably known that the Center prohibited leaving residents unattended in EZS's.

The Union also found it odd that no attendance sheet or agenda could be found for the meeting Zacho recalled holding regarding her EZS Policy, and that County Exhibit No. 4, (Zacho's Policy memo on the EZS) could not be found until just before the instant hearing. Where, as here, no evidence of the establishment of a proper policy/rule was submitted, where

no clear evidence was submitted to show that the County attempted to disseminate its alleged

policy/rule or to educate CNA's regarding the policy, Wess' discharge must be reversed. Indeed, the Union urged that there was no just cause for the prior (ungrieved) disciplinary actions taken against Wess, making the County's reliance thereon in this case "questionable" especially in light of Wess' "near perfect" performance evaluations.

REPLY BRIEFS

The County

The County noted that nothing in the EZS Manual "even suggests, much less approves" leaving a resident attached to an EZS. Rather, the Manual clearly states that after transfer/positioning a resident on a commode using the EZS "the harness should be unhooked and removed." Here, Wess failed to follow the EZS Manual as well as engaging in other misconduct.

The County urged the Arbitrator to analyze CNA Bennett's testimony which it argued showed Bennett's recollection of the March 18, 2005 J.R. incident was faulty and that the Union's leading questions of Bennett should not stand to contradict Zacho. In addition, the County noted that Morse never stated that Zacho's EZS Policy did not exist or that Zacho called no meetings to discuss it. Rather, Morse admitted being disciplined for violating Zacho's EZS Policy. Also, Brandon's testimony fell short of asserting that Zacho's EZS Policy did not exist – she only stated that she could not find a copy of it in 2005 when Wess was terminated.

Again, the Union's leading questions to Wess regarding her attendance at a CNA meeting where the EZS Policy was discussed should be disregarded leaving her original answers in place – that she did not recall attending such a meeting. Finally, the County implied that the fact that Wess failed to grieve any of the County's prior disciplinary actions puts the substance of these actions beyond the Arbitrator's authority to reach herein.

In the circumstances of this case, the County argued that any of Wess' misconduct of March 18, 2005, standing alone, would have justified her immediate discharge. However, Wess was far from a "near perfect" CNA as evidence by her disciplinary record which proved she placed her own concerns/comfort ahead of the residents'. The County urged the Arbitrator to assess and weigh the bias of the Union's witnesses (including Wess) against Zacho, a form Center DON who had nothing to gain by her testimony. The County contended it met its burden of proof herein that it was justified in terminating Wess, requiring an order denying and dismissing the grievance.

The Union

The Union asserted that because J.R.'s roommate is blind and Wess had closed the door to J.R.'s room, J.R.'s privacy was not truly violated by Wess' admitted failure to draw J.R.'s privacy curtain. Indeed, the Union noted, Zacho herself left J.R. on the commode in the EZS and exposed to her roommate, just as Wess had done. Therefore, the Union argued that Zacho's "outrage" at Wess' conduct was "feigned" and "fraudulent;" and that Zacho "lied" about her own conduct. The Union observed that given the amount of time many of the residents need to complete bowel movements, a CNA could not complete her tasks if she had to sit with each resident while they were on the commode.[4]

In addition, the Union contended that the County's sole reliance on Zacho's testimony to prove its case was ill-advised - - that the County had other witnesses it could have called to support their case. And, the Union asserted, its witnesses uniformly refuted each and every aspect of the County's case – from the circumstances on the day of the discharge, to the question of whether the "rule" was ever discussed with CNA's, to the circumstances surrounding the grievant's prior discipline. Finally, the Union urged that neither Bennett nor Morse stated that they knew of Zacho's EZS rule until after Wess' discharge, requiring a conclusion that Zacho discharged Wess "without any regard for the truth." The Union therefore sought a full make-whole remedy for Wess including reinstatement.

DISCUSSION

As a preliminary matter, I note that the Union has argued that the prior discipline given to Wess should be disregarded as unfair because it was 1) given to her without affording her a Union representative (oral and written warnings only, by Wess' admissions); 2) Wess was unaware of her contractual rights to file grievances in 2004; 3) Wess was not asked to give any justifications or explanations for her actions which might have resulted in her being given lesser or no discipline for the incidents in 2004. Here, the prior disciplinary actions against Wess were progressive in nature, beginning with an oral warning, followed by a written reprimand and ending with a one-day suspension, all for misconduct similar to that which occurred on March 18, 2005.

In my view, the merits of the oral and written reprimands and Wess' one-day suspension may not, in fairness be resurrected by the Union during Wess' discharge hearing precisely because Wess failed to timely file grievances thereon to contest the merits of the discipline. It is axiomatic in labor relations that employers and unions must be able to rely upon the grievance procedure and the time limits contained therein such that if no grievances are filed or an answer is late, the untimely party must suffer the consequences of their inaction

4 The Union offered no evidence to support these assertions.

and be said to have thereby waived their right to further pursue the merits of the disciplinary

action taken. If this rule were not followed, a party could revive and try stale, time-barred cases and/or raise arguments and facts never previously raised during the grievance procedure whenever it was advantageous to do so. Allowing such a result would undermine the parties' relationship by allowing untenable uncertainty and potential abuses of the grievance process.

In this case, the effective contract contains a standard clause requiring grievances to be expeditiously filed yet allowing for mutually agreed-upon extensions of time to file and process grievances, as follows:

ARTICLE 4 – GRIEVANCE & ARBITRATION PROCEDURE

4.01 Definition of a Grievance: A grievance shall mean a dispute concerning the interpretation or application of this contract.

. . .

4.03 Time Limitations: If it is impossible to comply with the time limits specified in the procedure because of work schedules, illness, vacations, etc., these limits may be extended by mutual consent. All time requirements set forth in this Article, unless otherwise specified, are working days and are exclusive of Saturdays, Sundays and holidays.

4.04 Settlement of Grievance: Any grievance shall be considered settled at the completion of any step in the procedure, if all parties concerned are mutually satisfied. Dissatisfaction is implied in recourse from one step to the next.

4.05 Steps in Procedure

Step 1: The employee, alone or with his or her representative, shall orally explain his or her grievance to his or her supervisor no later than ten (10) days after he or she knew or should have known, of the cause of such grievance. In the event of a grievance, the employee shall perform his or her assigned work task and grieve his or her complaint later. The supervisor shall, within four (4) days, orally inform the employee, and the representative, where applicable of his or her decision.

. . .

Significantly, no evidence was proffered to show that Wess or the Union requested any extensions of time to file grievances on behalf of Wess.

Wess' testimony, elicited by the Union, also shows that Wess' father was a union officer at the Fox Valley Correctional Facility and that her grandparents were knowledgeable

about unions (Tr. 198-99). Wess also stated herein that in 2002-03, she attended a Union

conference where she learned more about the Union (Tr. 199). In addition, Wess signed two of the prior disciplinary actions taken against her without writing any objection/explanation thereon.[5] In all of the circumstances, the evidence failed to support the Union's argument that this Arbitrator should disregard the prior progressive discipline taken against Wess and it therefore stands against her in this case.

The parties have argued credibility in depth in this case, regarding Wess and Zacho's testimony. The Union has essentially pitted the credibility of the Grievant against that of former DON Zacho, while the County has argued strongly that Zacho must be credited herein. Based upon the following analysis of the Grievant's excerpted testimony, the documentary evidence and my analysis of the testimony of other Union witnesses, I find that Wess' version of the relevant facts is less reliable/credible than Zacho's testimony and where a conflict arose, I have credited Zacho over Wess.[6]

In this regard, I note that on direct examination by Mr. White, Wess made the following statements regarding her recollection and her knowledge of the August, 2001 incident where a resident was left unattended in an EZS and almost strangled:

A. (By Mr. White)

> The situation involves an incident that apparently had taken place in August of 2001. Now you were hired in July of 2001, so you were relatively a new employee?

A. Yes.

Q. And do you remember hearing this situation, that a resident ended up with a strap of the EZ Stand around his neck? Do you remember hearing about that?

A. I don't remember how I heard it, but I heard that one resident had played with a button because the emergency break was not on.

Q. Okay. Did you understand that henceforth, from this day forward, that

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5 Wess' recollection was sketchy regarding Zacho's involvement in Joint Exhibits 1 and 2 - - Wess stated she did not "believe" Zacho was present when she received the documents (Tr. 151, 155), while Zacho's recollection was clear, and the documents showed Zacho's initials indicating Wess was given a copy of the discipline.

6 Zacho's testimony concerning her normal business practices in personally investigating each incident, reading each disciplinary document to the employee and then initialing and issuing the discipline were supported by the documentary evidence showing Wess' prior disciplinary record, where each document showed Zacho's initials indicating that she gave a copy of the discipline to Wess. I note that none of the other Union witnesses was asked about Zacho's practices, except that Union steward Branton stated that she could not find Zacho's EZS memo until after Wess was terminated, not that such a memo never existed. Zacho struck this Arbitrator as a highly intelligent, well-organized, caring and straight-forward woman. Having left the Center's employ shortly after Wess' termination to take a nursing management job in Madison, Wisconsin, Zacho had no "axe to grind" in this case, unlike Wess whose job and backpay are at stake herein.

you were not to leave a resident unattended in an EZ Stand?

A. I don't recall –

Q. Okay

A. --- what was said to me or anything. I was on night shift then. (Tr. 171)

In my view, the above-quoted testimony clearly shows that Wess had heard about the August, 2001 incident but that she did not recall what was said to her about leaving residents unattended in EZS's--not that nothing was said to her on this point. It is significant that Union witness Morse stated that she was "written up" for having left a resident unattended in an EZS sometime between 2001 and 2006.[7]

Regarding her possible attendance at a CNA staff meeting where Zacho explained her policy (County Exh. 4) against leaving residents unattended in EZS's, Wess' recollection was hazy on direct as follows:

(By Mr. White)

Q. Did you attend a CNA staff meeting at which Ms. Zacho explained this policy?

A. Only time I ever attended a staff meeting is when it was mandatory because I lived far away.

Q. Okay, well, does that mean that you might have attended one at which that was mandatory that Ms. Zacho led and to talk about this?

A. Only if it was mandatory.

Q. Well, let me ask you this.
Do you remember ever - - mandatory or not, ever attending a CNA meeting in which Ms. Zacho talked about the policy regarding the EZ Stand?

A. No. (Tr. 171-172)

Significantly, Union Steward Brandon stated herein that she recalled that the August, 2001 incident that lead to Zacho's issuance of the EZS policy was discussed at a mandatory CNA training session and that all staff were present (Tr. 228-29). This evidence supports a

7 As no evidence was placed in this record concerning Morse's past disciplinary history, no conclusions can be reached regarding whether Wess' termination was a harsh punishment. Indeed, the Union placed no evidence in this record that showed that management was aware that other specific employees had left residents unattended in EZS's and no discipline was issued therefore.

conclusion that Wess attended the mandatory meeting at which the EZS Policy was discussed.

It is also significant that Wess never asserted that anyone in management ever told her that it was all right to leave residents in EZS's unattended, or that she was told this in training or as part of an instruction video on the EZS. On this point, Wess testified as follows:

(By Mr. White)

Q. Okay. In your training, what kind of training did you receive on the EZ Stand?

A. There was a video and watched people demonstrate how to use an EZ Stand.

Q. Okay. In that training did they tell you, don't leave a resident unattended in an EZ Stand?

A. The video never said it and the - - the visual was just how to strap them in and how to stand them up and position everything. (Tr. 172)

It is clear from the above excerpt that Wess failed to fully answer Mr. White's question leaving open and unanswered what Wess was told during training on this point.

Furthermore, a close analysis of the EZS Manual (Jt. Exh. 5) shows that at no point during the description of the operation of the EZS does the pictured nurse leave the patient unattended in the EZS. Indeed, the Manual clearly states that the device is to be used as a transferring device and that the nurse using it is expected to remain "beside" the patient during the use of the EZS.

It is also important to understand J.R.'s physical and mental condition on March 18, 2005. On this point, the record showed that J.R. was in the last stages of Alzheimer's disease; that she could not speak; that she could not walk or move without assistance; that J R was unable to make her thoughts and desires understood; that she would not have realized she was in need of help and that she could not have called out or even gestured or signaled of help. As Wess had cared for J.R. prior to March 18, 2005 and had read J.R.'s Care Plan (County Exh.5), Wess was fully aware of J.R.'s virtually helpless condition. And yet, Wess testified as follows:

(By Mr. White)

Q. Okay. At the time that you - - that the incident took place March 18th of 2005, did you believe that what you were doing was improper?

A. No. I believed she was safe.

Q. Okay. Were her arms suspended in the air?

A. No.

Q. Was the stand sling still around her?

A. This part was.

Q. All right, you're gesturing around your waist?

A. There's a strap that comes from back here and it's hooked up and comes down to about right here, so as you're sitting - -

Q. The problem is is that we're preparing a written record of what you're saying and you're gesturing.

A. Okay. There's a sling that goes across your back and comes up underneath your arms and attaches it. That was behind her.

THE ARBITRATOR: Attaches to what?

THE WITNESS: To the EZ Stand itself. (Tr. 173)

The Union asserted herein the County Exhibit 5 was created in September, 2005 after Wess was terminated, and that it should therefore be disregarded. This argument was not supported by the record testimony or the document itself. In this regard, I note that the comments that were made on County Exhibit 5 in September, 2005, all contained the verb "continue," implying that the actions/treatments described therein had been done in the past pursuant to other instructions contained in the document and that the September, 2005 notations were simply designed to reconfirm prior treatments/instructions. In addition, there were several notes in various places on the document with dates prior to Wess' discharge--references to J.R. being a "fall risk," needing to use the commode by her bedside and needing an EZS--all of which Wess confirmed were on JR' s Care Plan when she (Wess) reviewed it in July, 2004.

I turn now to an analysis of Wess' testimony regarding how she left J.R. on the commode on March 18, 2005:

. . .

BY MR. WHITE:

Q. Now one of the issues that has been raised about this incident is that you had the commode up against the closet door and not behind the privacy curtain. Why did you have the commode up against the closet door?

A. It doesn't move back when I have it in front of the closet door. If I were to put it anywhere, it would have to go in front of her chair, which is where she was going next. I would have had to leave her hanging there while I moved the commode out of the way to get her to her chair.

Q. Okay. Hanging there meaning strapped into the EZ Stand?

A. At full stance.

Q. Okay, which in your view, is that a more hazardous situation?

A. Leaving her hanging there, yes. (Tr. 174-175)

. . .

(By Ms. Wess)

A. The strap or the sling as it's called was behind her and it was attached to the EZ Stand. The buckle was not I believe around her - -

(By Mr. White)

Q. Okay.

A. - - as to squeeze her.

Q. Okay, so what's called the safety strap was not actually strapped?

A. Not when she was sitting down.

Q. Okay.

A. Because it squeezes her stomach.

Q. Okay, and but the loops were - - they were attached to the - - to the EZ Stand itself?

A. Yes.

Q. Okay.

A. I believe so.

Q. All right. And now was the - - what position best shows the - - the stance of the EZ Stand? Was it most like Figure 5 or more like Figure 6?

A. Figure 5 in the lowest position. (Tr. 184)

The above quotations demonstrate that Wess was aware that J.R. could have moved the commode and/or the EZS if Wess had not put the commode up against J.R.'s closet door. This proves that Wess knew that leaving J.R. in this position was not completely safe although Wess testified that she believed J.R. was safe (Tr. 173).

In addition, Wess' statement that she would have had to leave J.R. "hanging there" had she not done as she did on March 18, 2005, simply does not make logical sense as this was not truly one of Wess' options since J.R. had to use the commode before she was placed in her

chair that day and Wess could have stayed with J.R. rather than leaving her "hanging there."

Also, I note that Wess' reference to Figure 5 on Joint Exhibit 5 (the EZS Manual) shows the nurse standing next to the patient in the picture, in the process of putting the EZS harness on the patient and she is not shown not leaving the patient alone with a partially attached EZS.

Also, the EZS Manual states that the safety strap--which Wess admittedly chose not to fasten around J.R. before she left J.R. unattended in her room on the EZS with the door closed-- should be securely fastened around the chest of the patient "for the safety of the patient" (County Exh. 5). Clearly, J.R. could have slid/fallen off the commode and/or out of the EZS while unattended. It was doubly unsafe to leave J.R. in this position with the door to her room closed, as neither J.R. nor her roommate could not have been heard calling out for help, assuming one of them could have done so. No evidence was presented to show that J.R.'s roommate was cognitively or physically able to help J.R. or call out for help on her behalf. The fact that J.R.'s roommate was blind does not detract from the fact that Wess violated J R's privacy by leaving her exposed on the commode. It is undisputed that anyone could see J.R. from the doorway. Also, I do not believe that Zacho left J.R. exposed and unattended on March 18, 2005, as the Union alleged. Rather, Bennett stated that she was in the next room when Zacho called to her from the doorway to help J.R. (Tr. 113), which Bennett did immediately.

Finally, all witnesses who testified herein, including Wess, stated that they knew it was against Center policy to leave Alzheimer's residents alone on the Birch porch. In my view, Wess' leaving J.R. and her roommate alone in their room with the door closed was at least as dangerous as leaving residents alone on the Birch porch, and that this should have been clear to anyone who had worked with these residents for as long as Wess had done.

The Union has argued that Bennett's testimony requires a conclusion that Zacho was not telling the truth about what occurred on March 18, 2005. I disagree. A close analysis of Bennett's testimony shows that Bennett specifically stated that she did not recall and did not remember what position J.R.'s arms were in when she came into the room to help J.R. on March 18th (Tr. 114), but that Bennett then changed her testimony to state that J.R.'s arms were not elevated when pressed by the Union representative. Wess had similar problems in her testimony (quoted above) which demonstrated that Wess' recollection was sketchy and her statements changeable, at best. Also, Bennett did not corroborate Wess that Wess took J.R. off the commode on March 18, 2005, which evidence also undercut Wess' credibility.

One last quotation from Wess' direct testimony is very telling of Wess' understanding of County Exhibit 5 and what affect her actions would have on March 18, 2005:

(By Mr.White)

Q. Okay. Now it indicates then under the next column says fall risk. Does that relate anything to how you use the EZ Stand or the two person assist

or transfers?

A. You have to use a gait belt with the two person assist, but with transferring with the EZ Stand, you have to watch her very close and that's what you have to do with an EZ Stand.

Q. And that has to do with the act of actually transferring her?

A. Yes. (Tr. 178)

Based upon the above analysis, Wess' admissions herein, and the documentary evidence, I find that the County proved that Wess knew that she should not have left J.R. unattended in the EZS and that doing so would put J.R. in danger, given J.R.'s physical and mental condition. The record herein also supports the conclusion that the prior disciplinary actions taken against Wess were for the same type of misconduct-- neglect of and disregard for residents' needs--which Wess engaged in toward J.R. on March 18, 2005. Thus, in these circumstances, the County's decision to terminate Wess, after she had received an oral and a written warning and a one-day suspension for the same type of misconduct constituted progressive discipline which the Union otherwise failed to prove was unreasonable, arbitratory, discriminatory or capricious.

Therefore, I issue the following

AWARD

The Employer had just cause to terminate the Grievant. The grievance is therefore denied and dismissed in its entirety.

Dated at Oshkosh, Wisconsin, this 2nd day of November, 2006.

Sharon A. Gallagher /s/
Sharon A. Gallagher, Arbitrator

SAG/dag