

BEFORE THE ARBITRATOR

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In the Matter of the Arbitration of a Dispute Between

**SERVICE EMPLOYEES INTERNATIONAL UNION HEALTHCARE, LOCAL 150  
WISCONSIN, CTW, CLC**

and

**WAUKESHA SPRINGS HEALTH & REHABILITATION CENTER**

Case 4

No. 67287

A-6306

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Appearances:

**YingTao Ho**, Previant, Goldberg, Uelman, Gratz, Miller & Brueggeman, S.C., 1555 North RiverCenter Drive, Suite 202, P.O. Box 12993, Milwaukee, WI 53212, appearing on behalf of Service Employees International Union Local 150.

**Barry L. Chaet**, Beck, Chaet, Bamberger & Polsky, S.C., Two Plaza East, Suite 1085, 330 East Kilbourn Avenue, Milwaukee, WI 53202, appearing on behalf of Waukesha Springs Health and Rehabilitation Center.

**ARBITRATION AWARD**

Waukesha Springs Health and Rehabilitation Center, hereinafter Waukesha Springs or Employer, and Service Employees International Union Local 150, hereinafter SEIU or Union, are parties to a collective bargaining agreement that provides for the final and binding arbitration of grievances. The Union, with the concurrence of the Employer, requested the Wisconsin Employment Relations Commission to provide a panel of five WERC Commissioners or staff members from which they could jointly select an arbitrator to hear and resolve a dispute between them regarding the instant grievances. Commissioner Susan J.M. Bauman was so selected. A hearing was held on December 14, 2007 in Waukesha, Wisconsin. The hearing was not transcribed. The record was closed on January 8, 2008, upon receipt of all post-hearing written argument relating to the question of arbitrability of the grievance and a companion grievance. In a decision issued on January 30, 2008, the undersigned found the grievances to be arbitrable.

A hearing on the merits of the instant grievance was held on May 7 and 8 in Waukesha, Wisconsin. Transcripts of the hearing were filed by May 22, 2008 and briefs were filed by July 2, 2008. On July 3 the parties advised that no reply briefs would be filed, whereupon the record was closed.

Having considered the evidence, the arguments of the parties, the relevant contract language, and the record as a whole, the Undersigned makes the following Award.

### **ISSUE**

The parties stipulated that the issue to be decided is:

Whether there is just cause for the discharge of Elaina Galmore and, if not, what is the remedy?

### **BACKGROUND and FACTS**

Waukesha Springs Health and Rehabilitation Center operates a state licensed skilled nursing home in Waukesha, Wisconsin. Among the services it provides are continuing maintenance and therapies for an older adult population needing skilled nursing care and rehabilitative services for residents after surgical procedures. Michael Libby serves as the administrator of Waukesha Springs, a position he has held since July 2006. Waukesha Springs is one of five or six skilled care facilities within a ten-mile radius of Waukesha. All of these facilities draw from the same referral sources and are effectively in competition with one another. In order to enhance its market position, Waukesha Springs focuses on delivering a higher standard of care and concentrates on patient satisfaction. It does this, in part, by strictly enforcing rules and regulations relating to patient rights.

The Waukesha Springs Employee Handbook contains a section on Resident Rights:

You will be provided with a caregiver pledge and information on the facility procedures related to resident rights and client protection. Your understanding and observance of resident rights and client protection are essential to your efforts to provide the best possible care to residents. You are responsible for knowing and observing these rights and policies. Above all, this facility is our resident's home and all employees must respect that.

The Handbook also contains a section requiring the reporting of Resident Abuse and Neglect:

Waukesha Springs strongly support resident's rights and, therefore, the Facility will not tolerate the physical, verbal, or emotional/psychological abuse of a resident, or neglect of resident care duties related to safety, health, and/or physical comfort of our residents.

In caring for residents, be particularly careful that none of your actions could be misunderstood by other residents, employees, family members, or visitors. Even when you had proper intentions, it may be difficult to defend yourself against a charge of abuse or neglect. In some instances, it may be in your best interest and the best interest of the facility to have another staff member present during the interaction or cares of some residents. That second staff member would act as a witness to your interaction.

There may be occasions when a resident may be abusive or abrasive toward you. You must remember that a resident's actions may be a result of the aging process, certain illnesses, or because the resident is unhappy with his or her current situation. Sometimes, a resident may direct hostility toward you. Remember that this is not really personal against you. Report such incidents immediately to your supervisor or department manager for the protection of all parties involved.

If you are a witness to a situation where you believe the resident's physical, mental or general well being had been or may be abused or neglected, you must report it immediately to your supervisor, department head, or by using the Corporate Compliance Resident Safety Line at [].

In accordance with State of Wisconsin licensing requirements, the Employer also posts flyers throughout the facility notifying Residents and their Families of their rights under the law:

***ATTENTION  
RESIDENTS AND FAMILIES***

Do you have questions or problems concerning your care and treatment at this facility?

***Ombudsmen***

are advocates who protect and promote the rights of residents in nursing homes and group homes.

**Resident Rights include:**

- The right to be treated with dignity, courtesy and respect
- The right to good quality care and a good quality of life
- The right to be free from abuse and chemical and physical restraints
- The right to be fully informed and make decisions about care and daily routine
- The right to not be involuntarily discharged without due process
- The right to privacy and confidentiality
- The right to establish and freely participate in Resident and Family Councils

**Call 1-800-815-0015**

If you have questions or concerns about your rights and care. An Ombudsman will assist you by providing information, investigating your concerns, and working with you and your caregivers toward problem resolution.

State of Wisconsin  
Board on Aging and  
Long Term Care  
214 N. Hamilton St.  
Madison, WI 53703-2118

In addition, the Employer publishes a brochure entitled Resident Rights & Protection. Section 4 of that document addresses Dignity and Respect and what residents and their families can expect from Waukesha Springs:

This facility will care for each of its residents in a manner and in an environment that promotes, maintains and enhances each resident's quality of life.

We will promote your right to receive care and treatment in a manner and in an environment that maintains or enhances your dignity and respect in full recognition of your individuality.

You have the right to reside and receive services in the facility with reasonable accommodation of your individual needs and preferences, except when the health or safety of you or others would be endangered. You have the right to:

- Choose activities, schedules and health care consistent with your interests, assessments and care plans.
- Interact with members of the community both in and out of the facility and
- Make choices about aspects of your life in the facility that are significant to you.

You, as a resident, have the right to be free from the imposition of physical restraints or psychoactive drugs administered for the purpose of discipline or conveniences and which are not required to treat medical symptoms.

You have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion. This facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect or abuse.

Waukesha Springs employees are trained with regard to the Ombudsman program and the need to respect patient rights and prevent patient abuse and neglect, in accordance with the above.

The facility is comprised of a number of separate units. In particular, on the second floor, there are two units: 2 Center and 2 North. 2 Center has hospice beds, mid- to end-stage dementia patients, and clinically complex residents, including those with cognitive impairment and physical challenges. The resident capacity on 2 Center is approximately 44. This unit is staffed with two nurses and four certified nursing assistants on days and p.m. shifts. Certified nursing assistants, CNAs, are charged with assisting residents with every aspect of their daily living throughout the course of the day. This includes providing assistance with toileting, dressing, eating, ensuring that residents are clean, dry and odor-free and

maintained in a dignified and respectful manner. At the start of each shift, the CNAs are given a list of residents for whom they are the “primary” for that day. Each CNA is the primary caregiver and has primary responsibility for eight to nine residents. The primary is charged with bathing, dressing, preparing for breakfast, grooming, and the like for those on her list.

In addition to providing care for those for whom a CNA is the primary, all CNAs and all other Waukesha Springs staff are required to respond to call lights from all residents. These are signals used by the residents to let the staff know that they are in need of help or assistance. Generally, CNAs respond to call lights, but if an RN or other staff member is the person closest when the light comes on, that individual is charged with responding to the request for assistance. Staff who are visiting on a unit to which they are not assigned are also supposed to respond to a call light if they are the nearest available person. No record is maintained of whose light goes on when, or of what staff person responded to the light, or what services were requested or rendered in response to the call light.

LV<sup>1</sup> became a resident of Waukesha Springs on or about September 27, 2006<sup>2</sup>. She suffered from some dementia and had medical problems that required the use of a wheelchair and oxygen. On the morning of September 28, VH was her primary care giver. The Grievant was the primary caregiver for LV’s roommate, E\*.<sup>3</sup> There were a number of other CNAs on the floor that day, NR, JA, and, perhaps, MB. In addition two RNs and SW, a restorative aide, were working on 2 Center at least part of that morning.

The Grievant responded to LV’s call light around 10:00 a.m. and toileted her, and thereafter returned LV to her bed with oxygen and some water. VH, LV’s primary care giver that day, took a break at about 11:15 a.m. Prior to going on break, at about 11:00 a.m., VH checked on LV who was clean with no complaints at the time. VH returned from her break at approximately 11:45 a.m., at which time LV’s call light was on and VH entered the room. LV was upset. Upon inquiry, LV indicated that she had gone to the bathroom on herself. This confused VH inasmuch as LV was not incontinent. Upon inquiry, LV told VH that another aide had responded to a call light and told LV to go in her briefs and that she, the aide, would return later to clean her, LV, up. VH took LV into the bathroom and helped her clean up. LV had urinated and defecated in her underwear. LV did not know who the aide was, but described her as black, with short hair, and overweight.

VH was of the opinion that the Grievant and NR were on the floor while she, VH, was on break. Except for VH herself, all of the CNAs working that day fit the description of black, short-haired, heavysset: JA, MB, NR, and the Grievant as well as SW the restorative aide. In fact, the nurses on duty that day also fit the description.

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<sup>1</sup>The testimony is conflicted as to the first day LV was at Waukesha Springs. However, there is no question that she was only there for a day or so before the events giving rise to this grievance occurred. Initials will be used herein to protect the privacy of the resident in question as well as that of the Grievant and other CNAs who were employed by Waukesha Springs at the time of the incident in question.

<sup>2</sup> All dates are in 2006 unless specified otherwise.

<sup>3</sup> E’s surname was not mentioned at hearing. Accordingly, she is being referred to as E\*.

In accordance with her responsibility under Waukesha Springs policies and procedures, VH reported this incident to CR, the RN unit manager and assistant Director of Nursing. CR conducted an investigation. He spoke with LV who confirmed VH's report of the incident. CR's written report indicates that the date of the report is 9-28-06, but there is no time of interview indicated. CR asked LV if she could identify the aide if she saw her and LV responded in the affirmative.

In an attempt to identify the aide who told LV to go in her pants, CR asked the Grievant to assist with repositioning of E\*. The Grievant did so and then wheeled E\* out of the room. CR also left the room. LV then pulled her call light and when CR re-entered the room, she reported to CR that the Grievant was the "one".<sup>4</sup> CR then asked restorative aide SW to come into the room, ostensibly to clarify a question about LV's wheelchair. After SW left the room, CR asked LV if SW was the one. LV emphatically said no, it was the other one, meaning the Grievant.

Subsequently, around 1 p.m., Social Worker MM interviewed LV to ensure that the incident occurred as VH had reported and that LV was consistent in her reporting of the incident. MM made a written record of her interview with LV:

- Q. Can you tell me what happened this AM?  
A: Oh, someone took care of that already this morning.  
Q: That's ok, [unclear] can you tell me so that we can make sure your needs are being met appropriately.  
A: Well I pulled the light. The aide came in. She said just go in your pants.  
Q: What did she do then?  
A: Then she left.  
Q: Did she come back?  
A: No  
Q: How did you get help?  
A: Another nurse came in and helped me.  
Q: Did you have to wait a long time?  
A: No, just a short time.  
Q: Can you tell me what this person looked like?  
A: You know that was a long time ago.  
Q: Do you know her name?  
A: You know I can't remember. I talked to someone earlier about this. It's ok.

CR also interviewed NR and JA. The record of the interview of NR does not include a date or a time. NR told CR that she had gone into LV's room around 1400 and toileted her. NR stated that she had not had contact with this resident prior to the time indicated, 1400. The

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<sup>4</sup> The Grievant testified that CR asked for her assistance on 9/29, not on 9/28. SW testified that she was called into LV's room by CR on both 9/28 and 9/29. I have found that the "identification" process took place on 9/28 as it is more logical for CR to have attempted this process on the same day as the event took place rather than on a subsequent day.

interview of JA is dated 9-28-06 and indicates a time of 1415. JA stated that she had answered LV's call light at about 1245 that day and that she had not gone into the room prior to that time, nor had she assisted with any of LV's cares.

CR did not interview MB. He did interview the Grievant. The record of that interview is dated 9-29-06, but no time of interview is indicated. The Grievant stated that she had responded to LV's call light about 10:00 a.m., at which time she had toileted the resident and transferred her back to bed.

On Friday, September 29, the Grievant was paged right before she was going to leave around noon. She went to the Human Resources office and was told that she was being suspended due to allegations of resident abuse. The following Monday, October 2, the Grievant reported to work at her regular time of 6:30 a.m.<sup>5</sup> and was told that she was terminated. The discharge notice is dated 9/29/06 and states that the discharge is the result of a Class 3 offense. The **violation**: "On 9/29/06 you refused to take a resident to the bathroom telling resident to go in their pants and you would clean them up." The **Standard of Conduct, disciplinary procedures/Bargaining Agreement Reference**: "Class 3 offenses pg. 15 #9 & 10 employee handbook. #9 Conduct seriously detrimental to facility rights, reputation or business operations or interest. #10 major deliberate or grossly negligent failure to perform job or essential duties." The Grievant completed the form, **Employee remarks**, with the statement "I wasn't the one to tell the resident to go in her pants. I would never tell anyone to do such a thing."

A grievance was timely filed and the matter is properly before the undersigned.

Additional facts are included in the **Discussion**, below.

### RELEVANT CONTRACT PROVISIONS

#### ARTICLE 2 - AGREEMENT RIGHTS AND EMPLOYER COMMITMENT & RIGHTS

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#### Section 2.2 Employer Rights

The Employer retains all rights and prerogatives necessary or appropriate to manage, operate, and conduct the Employer's obligations. Such management and direction shall include, but is not limited to, the rights to:

1. Hire, layoff, promote, demote, suspend, transfer, discharge or discipline for just cause
2. Maintain discipline
3. Determine, assign and delegate work

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<sup>5</sup> The Grievant worked the day shift. Her regular hours were 6:30 a.m. to 2:30 p.m.

4. Select, determine and re-determine the number of its employees
5. Determine quality and quantity of work performed
6. Maintain and improve efficiency, technology, equipment, facilities and methods of operations
7. Determine methods of compliance with federal and state rules and regulations affecting Nursing Homes and require compliance with same
8. Establish work rules, direct and schedule the working forces
9. Determine the number of hours, starting and ending times to be worked, including overtime
10. Determine the materials, means and type of services provided
11. Determine the methods, supplies and equipment to be utilized
12. Discontinue jobs
13. Determine job content and qualifications
14. Decide employee qualifications consistent with federal and state standards
15. Observe and evaluate employee job performance
16. Manage and administer Employer's operation and
17. Take whatever action is necessary in case of emergency.

## **ARTICLE 19 DISCIPLINE**

### Section 19.1 Just Cause

After completion of the probationary period, no Employee shall be disciplined or discharged except for just cause.

### Section 19.2 Disciplinary Procedures

- a. Any employee who is disciplined, suspended, demoted or dismissed shall be given written notice of the reasons for such action. A copy of such notice shall be made a part of the Employee's personnel record. The Union shall receive a copy of all termination notices given to members of the bargaining unit. Any such action taken by the Employer during an Employee's probationary period shall not be subject to the grievance procedure.



b. The Employer will include a Union Worksite Leader at any investigatory meeting where disciplinary action against the employee may result, if such Union representation is requested by the Employee.

c. Step 1: Verbal Warning  
Step 2: Written Warning  
Step 3: Suspension and/or Final Written Warning  
Step 4: Dismissal

The Employer may, in its discretion, initiate discipline for just cause at any of the above steps based on the severity of the specific infraction.

d. All disciplinary notices may be subject to the Grievance procedure as outlined in the Agreement.

### **POSITIONS OF THE PARTIES**

The Employer summarizes its argument that it had just cause to terminate the Grievant:

Waukesha Springs terminated [the Grievant] effective October 2, 2006 because a resident, LV<sup>6</sup>, reported that [the Grievant], a certified nursing assistant (“CNA”), told LV to go in her pants when LV requested [the Grievant’s] assistance to go to the bathroom. Upon the conclusion of an investigation of LV’s complaint, Waukesha Springs concluded that the Grievant had engaged in misconduct, and terminated her for violating handbook policies. At the arbitration hearing, all of the Respondent’s witnesses, and the Grievant herself, acknowledged that, if the Grievant had indeed refused to toilet LV, and told her instead to go in her pants, this would be a terminable offense. Accordingly, while discharge arbitrations usually address both whether the conduct occurred, and the appropriate remedy, in this case, because of the acknowledgement by the Grievant that is conduct would be a terminable offense, the Arbitrator’s primary decision is whether or not the conduct occurred.

It is the Respondent’s position that the preponderance of the evidence presented at the hearing established that the Grievant engaged in the conduct for

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<sup>6</sup> Although the Employer used the resident’s first name and the Grievant’s full or last name in its brief, this excerpt continues to use people’s initials as above.

which she was discharged. LV consistently repeated what had happened to her to four (4) different staff members at Waukesha Springs, and all of the Respondent's witnesses testified that LV was lucid and credible in so reporting. Moreover, it is undisputed that the Grievant was assigned to LV's unit, and indeed, was in LV's room at or about the time the incident occurred. Moreover, all of the witnesses' signed statements, based upon contemporaneous notes, served to corroborate the witnesses' recollections of the incident, which occurred in the fall of 2006. Simply put, although the Grievant denies that she told LV to go in her pants, all of the other evidence presented was contrary to the Grievant's self-serving denial. Under the circumstances, the Respondent met its burden of proof, and the grievance should be denied.

The Union summarizes its arguments as follows:

On September 28, 2006, Waukesha Springs resident LV<sup>7</sup> went in her briefs sometime between 11:30 a.m. and 11:45 a.m. LV later told a CNA that somebody had told her to use the bathroom on herself, and described that somebody as black, heavy set, and with short hair. Waukesha Springs subsequently concluded that the someone was the Grievant. Waukesha Springs then fired the Grievant for violating two specific work rules only.

Waukesha Springs has failed to meet its heavy burden of proving that the Grievant was the person who told LV to go in her briefs. LV's hearsay statement allegedly identifying the Grievant should not be credited both because it is hearsay evidence not supported by corroborating evidence, and because of facts showing that the statement was not trustworthy: The statement was made after LV's memory likely faded, is inconsistent with the timeline established by the testimony of other witnesses, and is based solely on a voice rather than visual identification. Waukesha Springs also cannot use a process of elimination to point the accusing finger at the Grievant because the process of elimination argument incorrectly assumes that only the four CNAs could have refused to toilet LV, when in fact close to a dozen people could have been responsible for the refusal, even assuming the refusal to toilet did actually occur.

Waukesha Springs therefore cannot discharge the Grievant for refusing to toilet LV. Given the specificity of the discharge notice, Waukesha Springs can only rely upon class 3, rules 9 or 10; rather than the general just cause standard to justify its discharge of the Grievant. In fact, the Grievant cannot be charged with violating either rules 9 or 10 since the conduct of refusing to toilet LV did not have an *actual* detrimental effect on facility rights, reputation,

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<sup>7</sup> The Union, also, used the first name of the resident and the Grievant's name. The convention of using initials will be continued here as well.

business operations, or interest, while rule 10's usage of the term "major deliberate failure to perform job" as distinguished from the less severe offense of "deliberate failure to perform job" is too vague to be enforceable under the just cause standard. Waukesha Springs therefore lacked just cause to discharge the Grievant, regardless of whether she refused to toilet LV.

### DISCUSSION

At issue herein is the question of whether the Grievant refused to toilet LV. For purposes of this discussion, I credit the testimony of the witnesses and the reports of the individuals that support the contention that LV was told by a nursing assistant to "go in her briefs"<sup>8</sup>. Based on the consistency of the reports of LV's statements about the alleged event, I assume that it did occur. Although I did not have the benefit of hearing from LV directly, for purposes of this discussion and decision, the facts are that sometime after VH checked on LV's status around 11:00 a.m. on the morning of September 28 and before LV returned from her break at about 11:45 a.m. on the same morning, LV demonstrated a need for assistance by using her call light. A black, overweight CNA with short hair responded to the signal and, upon being advised by LV that LV needed to use the bathroom, the CNA responded that LV should go in her pants.

LV was a new admission to Waukesha Springs, having been a resident at most one or two days prior to these events. LV suffered from a number of physical problems as well as some dementia. The extent of dementia is unclear on this record, but it is apparent that there was concern about the authenticity of her report of the event, as demonstrated by the request that her mental status and recollection be evaluated by Social Worker MM even after she had given fairly consistent reports to VH, CR and SW. As a new resident, LV had not yet become familiar with the staff of the 2 Center unit. Her primary caregiver for the day in question, VH, had first cared for LV on the previous day, September 27. VH worked with LV for half an hour to an hour that day. The record is silent as to what other aides, other than restorative aide SW, worked with LV for any length of time. The Grievant acknowledged that she responded to LV's call light around 10:00 a.m. on the morning in question and toileted LV at that time. Two other CNAs, JA and NR, denied having been in LV's room that morning. MB, another CNA, may have been on the floor at the time but she was never interviewed as part of the investigation and did not testify at hearing.

The record is clear that, except for VH, all of the CNAs, and perhaps the nurses other than CR, on 2 Center fit the description LV provided of the individual who refused to toilet her: black, overweight, with short hair. VH testified that, to her knowledge, NR and the Grievant were on the floor when she left for her break. Both of these individuals fit the

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<sup>8</sup> The witnesses and the parties have used "go in your pants," "go in your briefs," and "go on yourself". This discussion will use various permutations of these words. The issue is not the words used but whether someone refused to toilet LV and if that someone was the Grievant.

description. The Grievant testified that she was in the dining room, assisting residents with various activities, from approximately 10:10 a.m. until she left for her break, at about 11:30 a.m. NR did not testify, and none of the other witnesses testified as to NR's whereabouts during the time period at issue, 11:00 to 11:45 a.m.

CR, as part of his investigation into the event, attempted to have LV identify the nursing assistant in question. For reasons known only to CR, he first brought the Grievant into LV's room. There is a significant discrepancy between CR's testimony as to when this took place and that of the Grievant who contends that it occurred on the day following the incident in question. Additionally, there is conflicting testimony regarding whether it was possible for LV to even see the Grievant as she assisted E\* into her wheelchair and removed her from the room. According to the Grievant, CR called her into LV's room on September 29 and the curtain was drawn around LV's bed at the time. This would make it impossible for LV to make a visual identification of the Grievant, and the Union argues that the identification LV made of the Grievant was vocal only. According to CR, the identification was made on September 28. It was included in CR's written report of the incident dated September 28, a report which does not address the positioning of the curtains.

Based on the sequence of events, it is most logical that the attempt at identification was made on September 28, and I credit CR's testimony and his written report that, indeed, CR asked the Grievant to accompany him into LV's room on September 28 and assist LV's roommate, E\*, into her wheelchair and take her from the room. The Grievant also disputes that CR returned to the room immediately thereafter when the call light came on. For the purpose of deciding this matter, I find that LV told CR that the Grievant "was the one who said that" after seeing the Grievant enter the room and deal with E\*. I also credit CR's testimony and written report that he then asked SW to enter the room, supposedly in order to clarify a question with regard to LV's wheelchair. Additionally, I find that LV did tell CR, after SW left the room, that SW was not the person who made the comment and that LV "emphatically stated 'NO', - it was the other one" to CR upon being asked if SW made the comment.

Although the Grievant contends that the identification was voice identification, not visual identification, it is not necessary to make a finding in that regard inasmuch as even if it were a visual identification, I find that it is insufficient to establish that the Grievant is the one that made the inappropriate comment to LV. There are numerous reasons for this finding.

The Grievant acknowledges that she had been in LV's room earlier in the day. She had toileted LV at the time, giving LV an opportunity to spend some time with her, getting to know her, or at least know what she looked like. Given LV's apparent mental state, and the fact that her primary, VH, looked very different from the Grievant, it is not unrealistic to believe that LV would recognize the Grievant and identify her as "the one", since LV had seen the Grievant before. There is no evidence that SW had been in LV's room prior to CR's request to SW to come into LV's room. Accordingly, it is not surprising that LV did not identify SW as the person who told her to go in her pants, particularly in light of her having already "identified" the Grievant.

Further, to the best of VH's recollection, the two aides that were on the floor when she left for her break around 11:15 a.m. were NR and the Grievant. NR fits the description of black, overweight, with short hair. LV was never given the opportunity to view NR and possibly identify her as the person who refused to assist her to the toilet. JA and, possibly, MB were also on duty that day, although there is nothing in the record as to whether either was on the floor during the time period in question, approximately 11:15 to 11:45 a.m. Both JA and MB fit the aforementioned description, but LV was never given the opportunity to indicate that either of them had refused to toilet her.

The Grievant denies that she told LV to go in her pants, and states that she would never do such a thing. The Employer dismisses the Grievant's denial as self-serving. By the same token, however, JA's and NR's written statements to the effect that they had never entered LV's room during the morning of September 28<sup>th</sup> are self-serving and uncorroborated statements. They may be truthful, or they may not be. It is possible that one or the other responded to the light and stood by the door, asking LV what she wanted and telling her to go in her pants. It is also possible that neither spoke with LV until much later in the day. It is possible that none of the aides was responsible for making the comment, the Grievant, JA, NR, or MB. It may have been one of the nurses who also fit the description LV gave. It could have been staff from another unit who was passing through the unit, saw the light go on, responded and told LV to just go in her pants and someone would clean her up later.

Too many questions abound as to who refused to toilet LV to find that the Grievant was the guilty party. LV was a new resident at Waukesha Springs. She did not know the staff, and the description she gave of the perpetrator fits too many people. In his investigation, CR did not have all the obvious people, the aides and nurses on the unit that fit the description, come into LV's room for her to make an identification from all of the possibilities.<sup>9</sup> LV had seen the Grievant, but probably not SW. It is easy enough for someone with full mental capacity to indicate that it is the person she has seen before as the one who made the statement. With the Grievant's diminished mental capacity, it is quite possible that she confused the Grievant who had toileted her in the morning with the person who refused to toilet her later in the morning, particularly given her newness to the facility and lack of familiarity with any of the staff.

On the record before me, I cannot find that the Grievant was the person who refused to toilet LV. I cannot find that she was not the person who made the statement in question. The Employer has the burden to demonstrate by a preponderance of the evidence that it was the Grievant who refused to toilet LV. The Employer has failed to meet its burden.

Although the Grievant and other witnesses testified that termination would be the appropriate discipline if an individual refused to toilet a resident and told them to go in their pants, the Employer, should it opt to include specific rule violations in a termination notice, must cite the correct rules. Having found that the Employer failed to prove that it was the

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<sup>9</sup> I do not reach the question of whether hearsay testimony regarding such an identification process would be sufficient to find the person identified to be the perpetrator. As the identification itself is faulty, there is no need to reach the question of what evidence would be necessary to prove the ultimate question of guilt.

Grievant that refused to toilet LV, I need not reach the various other issues presented by the Grievant, including evidentiary questions and questions of whether the rule violations cited in the termination notice are the appropriate ones to have been cited.

Based on the foregoing and the record as a whole, the undersigned enters the following

**AWARD**<sup>10</sup>

The Employer did not have just cause to terminate the Grievant.

The Grievant shall be reinstated to her prior position. Her personnel file shall be purged of all references to the termination. She shall be made whole for earnings and benefits lost as a result of her termination, less any interim earnings.

Dated at Madison, Wisconsin, this 18<sup>th</sup> day of August, 2008.

Susan J.M. Bauman /s/

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Susan J.M. Bauman, Arbitrator

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<sup>10</sup> The undersigned will retain jurisdiction over this matter for a period of 60 days following issuance of this award for the purpose of resolving issues of remedy.