

BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

LOCAL 1760-A, AFSCME, AFL-CIO

and

ST. FRANCIS IN THE PARK HEALTH AND REHABILITATION CENTER, INC.

Case 25
No. 68404
A-6342

(Larson Grievance)

Appearances:

Mr. James Mattson, Staff Representative, 8480 East Bayfield Road, Poplar, Wisconsin, appearing on behalf of Local 1760-A, AFSCME, AFL-CIO.

Mr. Joseph J. Roby, Jr., Attorney, Johnson, Killen & Seiler, P.A. 800 Wells Fargo Center, 230 West Superior Street, Duluth, Minnesota appearing on behalf of St. Francis in the Park Health and Rehabilitation Center.

ARBITRATION AWARD

Local 1760-A, AFSCME, AFL-CIO hereinafter "Union" and St. Francis in the Park Health and Rehabilitation Center, hereinafter "Employer," mutually requested that the Wisconsin Employment Relations Commission assign Lauri A. Millot to hear and decide the instant dispute in accordance with the grievance and arbitration procedures contained in the parties' labor agreement. The hearing was held before the undersigned on January 7, 2009 in Superior, Wisconsin. The hearing was not transcribed. The parties submitted letters in support of their positions by February 11, 2009, 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:

Did the Employer have just cause to discharge the Grievant, and if so, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

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ARTICLE 4 – MANAGEMENT RIGHTS

Section 1. The Employer shall have the sole and exclusive right to manage and operate its facility subject to terms of this Contract and applicable law, governmental rules and regulations, and the rights, which include but shall not be limited to:

- a. To manage all operations, activities and to direct its employees;
- b. To hire, suspend, discipline, or discharge for just cause;
- c. To promote, assign, transfer, lay-off and recall employees consistent with the terms of this Agreement;
- d. To relieve employees from duty for legitimate reasons;
- e. To maintain discipline and efficiency among employees;
- f. To determine the existence and description of vacancies;
- g. To decide the number and type of employees and utilize volunteers provided none of these bargaining unit employees are laid off or suffer a reduction of hours as a result of the use of volunteers;
- h. To contract for goods and services provided none of this bargaining unit's employees are laid off or suffer a reduction of hours as a result of these contracts;
- i. To establish reasonable policies and procedures;
- j. To determine the type, amount and scope of services to be provided to residents and the nature of facilities to be operated;
- k. To establish schedules of operation and determine the methods, procedures and means of providing services to residents.

Section 2. Nothing in the above provision is intended to limit any other rights of the Employer not specifically and expressly covered, provided that the exercise of any of the above rights, the Employer shall not violate any provisions of this Agreement.

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ARTICLE 19 – DISCIPLINE

Section 1. The parties recognize the authority of the Employer to discipline, discharge or take other appropriate disciplinary action against employees for just cause.

Section 2. The following shall be the sequence of disciplinary action:

- a). Oral reprimand
- b). Written reprimand
- c). Written reprimand with a one (1) day unpaid suspension as scheduled by the Employer
- d). Written reprimand with two (2) days unpaid suspension as scheduled by the Employer
- e). Discharge

The above sequence of disciplinary action shall not apply in cases where the infraction is considered just cause for immediate suspension or discharge.

The following lists some of the common infractions and their disciplinary actions. In general, any conduct, which exhibits disregard for the goals of St. Francis in the Park Health and Rehabilitation Center or the health and well being of its residents, may be grounds for immediate dismissal. **This list does not contain all actions that may call for disciplinary measures, but it is intended to be a guide, to help you avoid activities that are opposed to the goals of St. Francis Home.**

(bold in original)

Infractions for which you may be dismissed immediately, but are not limited to:

1. Failure to obey legitimate directions from a person in authority.
2. Failure to fulfill the requirements and responsibilities of your job as required by your job description.
3. Unauthorized possession, use, sale or distribution of alcohol, drugs, narcotics and other mood altering substances on St. Francis in the Park Health and Rehabilitation Center premises or Facility sponsored events.
4. The illegal manufacture, distribution, dispensing, possession, or use of controlled substances or drug paraphernalia [as defined by state and federal law] on home-owned premises or while engaged in agency-sponsored events.
5. Possession of weapons or firearms on facility premises.

6. Reporting for work under the influence of intoxicants, drugs or taking them while at work or being under the influence of prescription drugs per the facilities Alcohol, drugs & Controlled Substances policy. Any employee reporting for work, or at work, under the influence shall immediately be relieved from duty and sent home.
7. Falsification of own or another's time card.
8. Falsification of records or information.
9. Theft or misappropriation of home, employee or resident property or any form of dishonesty. Unauthorized possession or use of St. Francis in the Park Health and Rehabilitation Center's, resident's or another employee's property.
10. The employee, prior to accepting a gift, gratuity or tip, must consult and get approval of the Department Head. The Department Head will provide a written opinion with a copy provided to the employee and employees personnel file for future reference in case the donor was to challenge the staff member's action.
11. Consuming food or drink designated for resident use.
12. Physical, emotional, sexual or verbal abuse to residents, staff or family members or any other individual on the facility premises.
13. Engage in or be a party to Sexual Harassment.
14. Failure to report on the job incident, injury or illness.
15. Failure to report having a contagious disease.
16. Excessive absence or tardiness.
17. Absent two workdays without notice in one consecutive 365 day period.
18. Disclosing of confidential resident or company information.
19. Failure to view all mandatory facility training in-services within established time lines and/or failure to meet the states (sic) minimal training requirements for the employees (sic) certification/licensure. Time spent viewing in-service tapes in the Facility shall be compensated, provided the employee is on duty.
20. Failure to pass the caregiver backgrounds checks.
21. Threatening other staff, residents, or visitors in the facility.
22. Job Abandonment.

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BACKGROUND AND FACTS

This grievance arises out of a series of events that occurred on May 28, 2008 involving the Grievant and WB, a resident of the Employer's facility.

The Employer operates a five floor residential nursing care facility. The third floor has 60 beds with a census capacity of greater than 50 residents. Residents are divided into five groups (four if the census is lower) each of which is assigned a Certified Nursing Assistant (CNA). The Employer schedules CNAs to one of three shifts, morning, evening, or night, and CNA's are assigned to a different group of residents each week. Resident groups are assigned a numeric designation, average 12 residents to a group, and group assignments change every Monday. CNAs complete resident needs functions including bathing residents, walking residents and dressing residents

The Grievant, Joyce Larson, was hired by the Employer 35 years ago to a CNA position and held this position until her termination effective May 30, 2008. At the time of her discharge, the Grievant worked the 6:45 a.m. to 3:15 p.m. shift on the third floor. The Grievant's supervisor was Jessica Stoltman. The Grievant had no disciplinary record and her job evaluations were satisfactory

During the morning shift on May 28, the Employer did not assign five CNAs to the third floor. Rather, four CNA's were assigned including the Grievant, Karlie Lisdahl, Jeanette Larson (the Grievant's sister) and Michelle Nelson. Another CNA, Jim, was on the floor for a limited period of time, but was reassigned to the first floor.

WB was a resident on the third floor of the Employer's facility. WB arrived at the facility one to two months prior to May 28. During the week in question, WB was part of resident group 5.

When the Grievant arrived at work to start her 6:45 a.m. shift, she looked at the schedule and noticed that she was assigned to work with the group 5. This was not the group of residents that she had worked with all week (group 3). The Grievant viewed this as an error and switched herself with fellow CNA and sister, Jeanette, resulting in the Grievant and Jeanette being assigned to the same group of residents that they had been assigned the prior day.

At approximately 8 a.m., RN Supervisor, Jessica Stoltman, arrived on the floor. Stoltman reviewed the staffing schedule and noticed that the Grievant was not working with the group of residents that Stoltman had assigned her the prior evening. Stoltman paid special attention to the schedule because she had changed it the evening before due to an alleged resident complaint against the Grievant. Stoltman asked the CNA staff about the schedule change and the Grievant explained that she had made the change believing it to be an error. Stoltman informed the Grievant that the change was intentional due to a resident complaint against the Grievant. The Grievant agreed to locate Jeanette and exchange groups.

After Jeanette returned from break, the Grievant told her that they needed to switch back to the resident groups that they had originally been assigned that morning. The Grievant and Jeanette exchanged their assigned list of residents. This occurred between 9:30 a.m. and 10 a.m. Resident WB was included on the list that Jeanette gave to the Grievant.

WB's wife entered the facility sometime after 11 a.m. When she arrived on the third floor, CNAs Lisdahl and Joe were in the desk area and greeted WB's wife. WB's wife asked where WB was and was told that he was at rehabilitation. WB was, in fact, still in his room.

After lunch was served, Stoltman asked which of the CNA's was responsible for WB. The Grievant looked at her list of residents and responded to Stoltman that WB was her responsibility. The Grievant immediately went to WB's room to provide him assistance. This occurred sometime after noon.

Late in the afternoon on May 28, WB's wife met with Stoltman and Amanda Grzadzielewski, Social Worker, who was assigned to help with resident complaints. Grzadzielewski interviewed WB and completed a Grievance Complaint Form. Grzadzielewski concluded that WB suffered from Neglect in Care in as much as he went 45 minutes without assistance after putting on his call light.

Grzadzielewski's report was forwarded to the Director of Nursing, Kris Eaton. Eaton and Stoltman terminated the Grievant's employment. The Employer also submitted the incident to the State of Wisconsin, Office of Care Giver Responsibility, which responded a few days later indicating it would not take further action.

Individuals working on the third floor on May 28, 2008 and called as witnesses at hearing testified as follows:

Jessica Stoltman

Stoltman worked for the Employer for seven months beginning in the fall of 2007 and ending in the summer of 2008. Stoltman was the Nurse Manager assigned to the third floor and the Grievant's supervisor. In addition to supervising the CNA's on that floor, Stoltman prepared the schedule for the CNAs.

Stoltman testified that late in the day on May 27, 2008, she received a complaint from a resident. The resident did not want the Grievant to care for her. For the safety of the resident, Stoltman decided to change the schedule for the next day. Stoltman indicated that because she had issues with the CNA's changing the schedule, she wrote, "Do not change this schedule" on the schedule.

Stoltman testified she arrived at work at 8 a.m. and noticed that the schedule had been changed. Realizing that the Grievant and Joyce has switched groups, Stoltman spoke to the CNA staff in the breakfast area. Stoltman testified she "figured out that a person [resident] was not [being] cared for." Stoltman testified that she told the Grievant she needed to go back to her original group.

Stoltman testified that later that afternoon, physical therapy staff came to the third floor looking for resident, WB, at which time she determined that the Grievant had not taken care of

WB. Stoltman immediately located the Grievant and asked why WB had not been taken care of. Stoltman testified that the Grievant responded, "I forgot."

Stoltman reported the situation to the Director of Nursing. Stoltman identified it as a serious incident because "WB suffered irritation" as a result of his colostomy bag leaking into an open wound on his stomach and "WB's wife [was] upset."

Stoltman completed a Progressive Disciplinary Record on June 5, 2008. The form indicated that the Grievant's violations were "Failure to Follow Directions" and "Employee Changed schedule without conferring w/ supervisor." The disciplinary sanction imposed was "Immediate Termination, effective 5/30/08" and the following was written on the form, "Neglected resident XXXXXXXX 322-2 Incident turned over to the State of WI. Also had other resident complaints on same day."

Amanda Grzadzielewski

Grzadzielewski was employed at the facility from March 2008 to July 2008 as a social worker. Grzadzielewski assisted with residents complaints.

Grzadzielewski was called to Stoltman's office on May 28 and was told that a family member was making a complaint on behalf of WB. Grzadzielewski interviewed WB's wife who explained that she was upset because when she arrived at the facility at 11 a.m., she was told that WB was in rehabilitation and he wasn't.

Grzadzielewski testified that she spoke to WB. He explained that he put his call light on, that no one came to help him, that rehabilitation came to get him and he told them he needed to finish getting dressed, that CNA Karlie came in and turned off his light telling him that someone would come help him, and that no one came to help him.

Grzadzielewski completed a Resident Grievance/Complaint form on May 28. The form indicates that Joyce (CNA) and Karlie (CNA) were responsible for WB missing his rehabilitation appointment. Grzadzielewski's investigatory notes read as follows:

XXXX reported that at approximately 8:55 am on today's date he turned on his call light to get assistance in getting ready for his rehab appointment that was scheduled for 9:30am. While he was waiting a staff person from rehab came to the room to see if he was going to be ready for his appointment. He reported that he told them he was just waiting for someone to come and assist him in getting ready. XXXX reported that after approximately 45 minutes a CNA (Carley) came into his room, shut his call light off, and stated that she would find someone to help him. XXXX reports that no one returned to his room to help him.

It was reported by the rehab department that they had notified Carley that XXXX needed assistance in getting up so that he could make it to his appointment. It was in response to this notification that Carley went into XXXX room and shut off the call light and said she would find someone to assist him.

Resident's wife XXXX arrived at the 3rd floor nurses station approximately 11:05am. The two CNAs sitting at the nurse's station (Carley and Joe) told her that XXXX was down at his therapy appointment when in fact he was still in his room waiting for assistance.

It was reported by the RNMGR that Joyce (CNA) was the person assigned to work with XXXX this shift. When she was asked to go and assist XXXX she indicated that she was not aware that XXXX was assigned to her and she believed he was down at his therapy appointment. Joyce was instructed by RNMGR to go and assist XXXX.

Joyce Larson

Larson was a 34 year CNA with the Employer at the time of her termination. Larson worked full-time, earned \$14.51 per hour, and earned "lots" of overtime.

The Grievant testified that they were working short on May 28. She stated she looked at the schedule and noticed that her group assignment had changed from the day before and that her sister, Jeanette Larson, was assigned where she had been the day before. The Grievant testified that she thought it was an error since Stoltman has mistaken she and her sister in the past.

The Grievant testified she was in the breakfast area at approximately 8:15 a.m. when Stoltman asked her if she had changed the book. The Grievant responded that she told Stoltman she thought Stoltman had made a mistake. Stoltman told her that that a resident had complained about her which caused the change. The Grievant testified that she told Stoltman that she would change the groups back to how they had been.

The Grievant finished assisting residents in the breakfast area and then went to Stoltman's office and asked about the complaint against her. The Grievant stated that Stoltman told her she didn't know anything about it and that she (Stoltman) had to go to a meeting.

After her conversation with Stoltman, the Grievant stated she provided service to the resident in room 3342. Shortly thereafter, by 9:15 a.m., she spoke to Jeannette and told her that they needed to switch back to their original groups and then the Grievant and Jeanette exchanged resident lists. The Grievant then went to the North wing, room 320 and provided service and then was responding to a resident in a private room that had her light on multiple times. The Grievant testified that they began serving lunch at approximately 10:45 a.m. which

is 30 minutes later than when it is supposed to be served. The Grievant testified that she spent the next hour and one-half responding to call lights from residents.

At approximately 12:30 p.m. Stoltman came to the lunch area and asked who was responsible for providing care to WB. The Grievant testified that she looked at her list of residents and noticed that he was on her list. The Grievant indicated that she then went to WB's room and apologized. The Grievant recalled that WB was pleasant and told her that it was "okay" and "that it is my wife that is mad." The Grievant testified that WB told her he wanted to get up and go to physical therapy. The Grievant went to WB, emptied his bag (which was not leaking), helped him put on his shoes, brought him his wheelchair and then he left for therapy in his wheelchair. This occurred at 1 p.m. or a few minutes later.

Jeanette Larson

Jeanette is a 40 year CNA with the Employer. On May 28 she was working on the third floor. Jeanette is the Grievant's twin sister.

Jeanette testified that when she arrived at work at approximately 6:40 a.m., she went to the desk area and looked at the job assignments. Jeanette noticed that she had been taken off resident group 3, the group that she had cared for the previous day. Jeanette testified that she and the Grievant "thought it was a mistake" and so they switched back to their group assignments from the previous day.

Jeanette testified that WB was on the group 5 list, but that on May 28 group 5 had been divided between the four other groups. As a result, WB was added to group 3. Jeanette stated she was assigned WB the prior two days and that she did not help him get ready for a physical therapy appointment on either of those dates.

Jeanette testified that on May 28 she picked up WB's breakfast tray and asked him if there was anything she could do to help him and if he wanted his door open or shut. She stated she then went on break; somewhere between 9:30 a.m. and 10 a.m. She and the Grievant exchanged resident group lists when she returned from break.

Jeanette testified that she spent the rest of her morning working with residents. She stated that they were working short that day and that by lunch-time, they were 45 to 60 minutes behind.

Jeanette testified that supervisors in the past had told the CNAs to work out schedule changes amongst themselves.

Michelle Nelson

Nelson is a two year CNA who worked on the third floor, morning shift, with the Grievant.

Nelson testified she answered WB's call light.

Nelson testified that the CNA's regularly switch resident groups. Nelson stated that if a particular resident does not like her and she finds another CNA to care for that resident. Nelson stated a supervisor is not involved when she makes that switch. Further, Nelson stated that she was not familiar with a supervisor ever removing a CNA from one group and assigning to another.

Karlie Lisdahl

Lisdahl is a three and one-half year employee who worked on the third floor.

Lisdahl testified that when a resident makes a complaint against a CNA, the CNA's schedule is not changed. Further, that CNAs don't usually switch groups, but that when it occurs, management makes the change. Lisdahl stated that the only day that she recalled a supervisor making a change to a CNA's schedule was the day Stoltman changed the Grievant's schedule.

Sandy Tollers

Tollers provides physical therapy services at the facility. Residents do not have regular appointments with Toller. Rather, they come to see her at different times. WB was to receive therapy five days a week. WB had a practice of coming to therapy at 10 a.m. daily.

Tollers testified that on May 28 she stopped at WB's room at approximately 8:45 a.m. WB told her that he would be down to see her after his colostomy bag was switched. WB did not receive therapy services on May 28. Tollers testified that WB's colostomy bag leaked on May 28 and "busted" on May 27.

Additional facts as relevant, are contained in the **DISCUSSION**, section below.

ARGUMENTS OF THE PARTIES

Employer

The Employer maintains that just cause existed, consistent with the specific language of parties' collective bargaining agreement, to terminate the Grievant.

The plain language of the just clause and progressive discipline provisions, while unusual, explicitly provides the Employer the right to terminate the Grievant. The language of 19.2 not only expands the set of infractions that are terminable offenses, but also allows the Employer to skip progressive steps and go right to discharge. The language further allows the Employer to make disciplinary decisions without regard to the employee's prior record.

The language of 19.2 is designed to deter and punish conduct “which exhibits disregard for the goals of St. Francis in the Park Health and Rehabilitation Center or the health and well being of its residents.” The Grievant exhibited this type of conduct and her termination was warranted.

The Grievant “fail[ed] to obey legitimate directions from a person in authority.” She disobeyed her supervisor by changing her group assignment even in light of the fact that “Do Not Change” was written on the sheet. The Grievant disobeyed her supervisor by not providing cares to anyone in the group that she was assigned. The Grievant was verbally instructed to care for her originally assigned group during breakfast and instead of immediately providing for the needs of that group, she delayed her return to that group by one hour and then let the entire morning pass without providing any care to W.B.

The Grievant “falsifi[ed] records or information.” This occurred twice. The Grievant first reassigned herself and then reassigned another CNA to her group. The Grievant had no right to alter the assignment sheet.

The Grievant engaged in “physical, emotional ... abuse to residents.” Abuse is not limited to the most technical interpretation, but includes the concept of “neglect.” The Grievant did not check on W.B. all morning. She did not get him dressed, did not perform any morning cares, did not empty his colostomy bag and did not get him ready for therapy. This constitutes neglect consistent with the expansive language of 19.2(12). The fact that W.B. did not ask for assistance and did not suffer any serious harm does not negate the fact that the Grievant’s failure placed his health and safety in jeopardy, not to mention that he and his wife were justifiably upset.

Union

The Grievant was discharged due to the confusion over the posted work schedule and the resulting alleged neglect of a resident. The Grievant’s termination lacked just cause.

The Employer has a practice scheduling CNAs to a group of residents for a week at a time. When a CNA became aware that a resident made a complaint against them or when a CNA needed assistance with a particular resident, the CNAs would exchange the resident among themselves. Supervisors did not change group or resident assignments and at no time did the Employer distribute a memo or letter informing employees of a change in this practice.

The Grievant reassigned herself from group three to group one because she believed her assignment to group three was made in error. It was never her intention to disrupt the normal flow of work or to act in an insubordinate manner. It wasn’t until between 7:45 a.m. and 8:00 a.m. that she learned it was not a clerical error because her supervisor informed her that the change had been made due to a resident complaint.

The Grievant spent all morning providing cares to residents of the facility for the Employer. The staffing was short and CNA's are expected to provide care to several residents at one time which is difficult. When Stoltman inquired who was assigned to care for W.B., the Grievant responded she was and she immediately went and provided care.

The Employer failed to follow progressive discipline. While it may be that Article 19 lists violations that are grounds for immediate termination, the Grievant did not intentionally violate any work rules. The Grievant's actions were not intentional.

Just cause has not been met. First, the Grievant's actions were not intentional. Second, the Employer failed to consider the Grievant's 34 year exemplary work record. Third, the Employer deviated from an established practice when the Grievant's supervisor changed her resident group. Fourth, the Grievant was not informed that a resident had made a complaint against her. And fifth, the Grievant was dedicated to providing the residents the best care possible, even during the chaotic and busy workday of May 28, 2008.

The Union requests the Arbitrator sustain the grievance, reinstate the Grievant and make her whole for all lost wages and benefits.

DISCUSSION

This is a discharge case. The Union asserts that the Grievant's termination lacked just cause. The Employer not only maintains that just cause existed for termination, but that immediate termination was warranted.

Article 19 of the parties' collective bargaining agreement addresses the Employer's rights as it relates to discipline. The first section grants the Employer the right to discipline provided the Employer has met the just cause standard. The methodology of a just cause analysis looks first to whether the employee engaged in the behavior for which he was disciplined and second, whether the discipline imposed reasonably reflects the employer's proven disciplinary interest.

The second section memorializes progressive discipline and affirmatively obligates the Employer to follow progressive disciplinary except in those instances where the infraction is serious enough to warrant immediate suspension or discharge.

The section differentiates common infractions for which the Employer will follow progressive discipline and more severe infractions which the parties' have agreed are serious enough to warrant immediate termination.

The Employer argues that this case is governed by the latter and further, that a standard just cause analysis is not applicable. I disagree. Regardless of whether the progressive discipline language or the immediate discipline language is applicable, both first require a finding that the Grievant was guilty of the offense for which she was disciplined. The

difference between the two sections relates to penalty. If the offense is one which the Employer has listed as a terminable offense, then immediate termination is an option. Therefore, I will first address the behaviors for which the Grievant was terminated.

The Grievant was terminated effective May 28, 2008, but absent from the record is a termination letter. In looking to the documents admitted at hearing, there is no consistent reason cited for the Grievant's termination. The reasons cited by the Employer at hearing, specifically items four, six and twelve contained 19.2 of the labor agreement, are not referred to until approximately one month after the Grievant's termination. Looking at the reasons cited for the Grievant's termination, in chronological order:

- On May 30, 2008 the Human Resources Representative indicated on the Personnel Action Form that the Grievant was terminated for "Abuse of a Resident."
- On June 4, 2008 in an Investigation Summary Hess wrote the Grievant was "terminated due to failure to provide resident cares per the care plan and changing the schedule without authorization from a supervisor."
- On June 5, 2008 the Employer's Progressive Disciplinary Record cited "Failure to Follow Direction" as the violation, described the violation as "Employee changed schedule without conferring w/ supervisor," and further commented, "Neglected resident [322-2] Incident turned over to the State of WI. Also had other resident complaints on same day."
- On July 7, 2008 the Director of Nursing indicates the reason for discharge as "an infraction that lands under Article 19, section 2, page 20 and 21, numbers 2, 12 and 14 of the union contract."
- On July 28, 2008 Administrator Hess noted in correspondence to the Union that the Grievant was "terminated for job performance on 5/30/08."
- On August 7, 2008 following a second step grievance meeting, Hess wrote that the Grievant "failed to fulfill the requirements and responsibilities of your job description, and you did not obey the directions of the nurse manager."

The fact that the Employer cannot state, with consistency, the reason for the Grievant's termination is problematic. Generally, a discharge "must stand or fall upon the reasons given at the time of the discharge" and the employer cannot add other reasons at arbitration. WEST VA. PULP & PAPER CO., 10 LA 117, 118 (Guthrie, 1947). In this case, I do not know the reason that the Employer gave the Grievant at the time of discharge and based on the numerous reasons that arose thereafter, it is clear that this has become a moving target. As such, my

analysis as to whether the Grievant was guilty of the wrongdoing for which the Employer terminated her will address the two incidents cited by her supervisor and understood by the Union to be the basis for the termination.

Change to Work Schedule

The Employer disciplined the Grievant for making a change to the work schedule. The evidence establishes that when the Grievant arrived at work on May 28, she looked at the schedule, believed that a mistake/error had been made when she was reassigned from resident group (which she had been assigned and working the prior day) to group 3 and, as a result, changed the schedule to that of the previous day.

The Employer's first documentation of the discipline indicates that the Grievant "changed the schedule without authorization from her supervisor." Stoltman's testimony establishes that she was "trying to keep it where the supervisor was making the decision [to make schedule changes] and not the CNAs." The facts establish that the Grievant changed the work schedule, but I do not find it was without authorization.

CNAs have a history of making unilateral changes to the schedule. Of the four CNAs that testified at hearing, all but one confirmed that this was the manner in which the CNAs handled conflicts between themselves and a resident and further that they have traded residents. This is corroborated by Stoltman's testimony wherein she stated that employees were "always making changes to the schedule." While it is unclear how long CNAs had made changes to the schedule, it is clear that they have done so for an extended period of time. I find the Grievant's action to be consistent with previously acceptable workplace behaviors.

Interestingly, Stoltman wrote "do not change" on the schedule for May 28. Stoltman was not asked why she chose on that particular day to make such a notation nor did she offer an explanation. The Grievant admitted to seeing a notation on the schedule, but claimed at hearing that she did not know that a triangle translates to "change" in medical shorthand. The Grievant is a 25 year veteran of the medical care profession and it is highly unlikely that this was the first time that she was exposed to the symbol for "change".

Ultimately I am asked to find fault in the Grievant's changing of the schedule. No evidence was presented at hearing indicating that the Employer maintained a rule or policy against employees changing the schedule. There was testimony that CNAs were permitted, *carte blanche*, to change the schedule and further that the first time that the Employer attempted to change this behavior was on May 28 when Stoltman wrote on the schedule. Had the Employer wanted to stop employees from changing the schedule, it was obligated to not only inform them of the expectation, but also put them on notice that should they make changes to the schedule, they would be subject to disciplinary sanctions. It did not do so. Thus, while a reasonable employee in the Grievant's position might have expected correction from her supervisor for mistakenly changing the schedule, she could not possibly expect serious

discipline, much less termination. The Employer's decision to discipline the Grievant for changing the work schedule was arbitrary and cannot be upheld.

Neglect of Resident

The second offense for which the Employer disciplined the Grievant was her failure to provide nursing care to resident WB. The Employer holds the Grievant solely responsible for the omission of care for WB on May 28. The Union challenges this portion of the discipline on the basis that the Grievant, in good faith, provided the residents on the third floor the best possible care she could on May 28 and that WB was not neglected.

I start with what the facts establish. Prior to the start of the Grievant's shift, she was assigned to resident group 5 and therefore responsible for WB. When the shift started, the Grievant switched groups with her sister. Therefore, from approximately 6:45 a.m. to 10 a.m., Jeanette was responsible for WB. Jeanette testified that when she removed his breakfast tray, she asked him if he needed assistance and he responded that he did not.

The record establishes that at approximately 8:55 a.m. WB activated his call light. Nelson responded to the call light and learned that WB wanted assistance. Nelson told WB she would get him some assistance. Nelson left WB's room and asked another CNA, Joe, if he would help WB. Joe declined stating that he was going back to first floor. According to Nelson, that is when Lisdahl offered to help WB. Lisdahl admitted to offering to help WB and confirmed that she did not help WB because he was assigned to Jeanette and Lisdahl concluded Jeanette could do it.

Grzadzielewsk's investigative report concluded that WB was neglected when he lit his call light and it was not answered resulting in him missing his rehabilitation appointment.¹ The Employer's conclusion that the Grievant was responsible for and guilty of this neglect is unfounded. At the time the call light was activated, Jeanette was the CNA assigned to WB. Jeanette was not informed that WB had activated his light, but both Nelson and Lisdahl knew that WB had activated the light, knew that he wanted help getting dressed and neither assisted him. The Grievant cannot be held responsible for failing to respond to WB's call light and failing to help WB get dressed when she had no knowledge of WB's needs or request. The Grievant was working with another group of residents; residents which she accepted responsibility to assist consistent with the Employer's schedule changing practices.² If there is guilt to be distributed for WB's lack of care before 10 a.m., then it must be assigned to

¹ The Employer documents that WB missed his scheduled physical therapy appointment. The Grievant did not have a physical therapy appointment. Rather, the Grievant would go to physical therapy, usually at 8:30 a.m., but there was not specific time set for his service to be delivered.

² While never articulated, the Employer's conclusion that the Grievant was responsible for WB for the entirety of May 28 appears to rely on the original Stoltman assignment. The Employer's position is illogical. An employee cannot be held responsible for something for which she does not have the authority to control. Whether she should have switched the assignment or not, the fact is that other employees were assigned to care for WB when this neglect occurred.

Jeanette Larson, Nelson, and Lisdahl and no evidence was presented at hearing indicating that any of them were disciplined.

The Grievant was told by Stoltman during breakfast that she was to provide CNA care to the resident group that she was originally assigned. The Grievant informed Stoltman that she would locate Jeanette and exchange resident lists. That is exactly what the Grievant did. Sometime between 9:50 a.m. and 10 a.m. the Grievant located Jeanette and the switched resident groups. Therefore, as of approximately 10 a.m., the Grievant became responsible for WB. Thereafter, she did not check on WB until asked by Stoltman at which time she responded that she had not, but would immediately. The impetus for Stoltman's inquiry was the arrival of WB's wife at the facility at approximately 11:05 a.m. at which time she was initially misdirected to physical therapy in search of her husband, only later to learn that the GB was not dressed, had not left his room, and had not received his physical therapy service.³

The Grievant admitted that she did not check on WB because she believed he was at physical therapy. While I do not accept that it is appropriate for a caregiver to not check on a resident, her conclusion that he was dressed and at physical therapy by that time of day was not so egregiously negligent that it would warrant the summary discharge of an employee with thirty-five years of satisfactory service.

In the end, there are at least three individuals, in addition to the Grievant, that were responsible for WB not receiving care the morning of May 28. It is generally accepted that

There must be reasonable rules and standards of conduct which are consistently applied and enforced in a non-discriminatory fashion. It is also generally accepted that enforcement of rules and assessment of discipline must be exercised in a consistent manner; thus all employees who engage in the same type of misconduct must be treated essentially the same. Elkouri & Elkouri, *How Arbitration Works*, 6th Ed. (2006) p. 996 citing *MUNSTER STEEL CO.*, 108 LA 597 (Cerone, 1997).

The record establishes that the Employer subjected the Grievant to disparate treatment when it regarded the Grievant differently even though the nature of the offense, the degree of fault and the existence of mitigating factors – the floor was working short – were the same. There is no excuse for failing to provide WB the care to which he was entitled on May 28, but the Employer's decision to hold the Grievant solely accountable is a stretch that cannot be upheld.

³ In addition to WB's wife complaining, the evidence establishes that the Employer had other concerns relating to resident WB's care. Witnesses testified to their understanding that WB's colostomy bag had broken or leaked the day before, that the bag was leaking on May 28, that GB had an open wound that was irritated by the colostomy bag, and that the registered nurse failed to change the bag the morning of May 28. It is evident that these extra curricular events, whether proven or otherwise, significantly affected the response to this situation, but while they may reflect poorly on the general care given to WB on these days, they do not involve any action, much less any misconduct, by the Grievant.

The Employer argued at hearing that the Grievant's behavior violated various infractions contained in the immediate termination section of Article 19. It need be noted that the Employer did not rely on the immediate termination portion of this article until long after the decision to terminate was made and therefore I do not accept that the termination was effectuated as a result of the terminable offenses portion of the article. Even if it had cited the appropriate rules at the time of discharge, the evidence does not establish that the Grievant was guilty of those infractions, nor does it support a finding that the Grievant was treated in a fair and just manner.

In conclusion, the Employer subjected the Grievant to disparate treatment when it imposed the most severe form of discipline for making a schedule change and the omission of care for WB on May 28. The Employer's decision was an arbitrary and capricious over-reaction to the events of the day and cannot be upheld.

AWARD

No, the Employer did not have just cause to discharge the Grievant.

The Employer is directed to reinstate the Grievant with back pay and make her whole for any losses that she has suffered as a consequence of her termination. The Employer will reinstate the Grievant's seniority date. The Employer is entitled to offset its back pay obligation by interim earnings and unemployment compensation, if any.

Dated at Rhinelander, Wisconsin, this 11th day of May, 2009.

Lauri A. Millot /s/

Lauri A. Millot, Arbitrator