

BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

GRANT COUNTY

and

**GRANT COUNTY EMPLOYEES, LOCAL 3377,
WISCONSIN COUNCIL 40, AFSCME, AFL-CIO**

Case 105
No. 68001
MA-14078

Appearances:

Neil Rainford and **Michael Wilson**, Wisconsin Council 40, AFSCME, AFL-CIO, 8033 Excelsior Drive, Suite “B”, Madison, Wisconsin, 53717-1903, appearing on behalf of Grant County Employees, Local 3377, Wisconsin Council 40, AFSCME, AFL-CIO.

Daniel Finerty and **Jon Anderson**, Godfrey & Kahn, S.C., One East Main Street, Post Office Box 2719, Madison, Wisconsin, 53701-2719, appearing on behalf of Grant County.

ARBITRATION AWARD

Grant County (“County”) and the Grant County Employees, Local 3377, Wisconsin Council 40, AFSCME, AFL-CIO (“Union”) are parties to a collective bargaining agreement that provides for final and binding arbitration of disputes arising there under. On May 12, 2008, the Union filed a request with the Wisconsin Employment Relations Commission seeking to have the Commission appoint a member of its staff to hear a grievance arbitration pending between the County and the Union. Following concurrence from the County, the Commission appointed the undersigned to hear and decide the matter. After a period of abeyance requested by the parties to allow an ancillary matter to proceed, hearing was held on July 29, 2009, and August 4, 2009, in Lancaster, Wisconsin. A transcript of the proceedings was taken and distributed by August 14, 2009. Post-hearing initial and reply briefs, totaling 146 pages, were filed by October 27, 2009.

On October 30, 2009, the County filed a motion to supplement the record or in the alternative to strike a portion of the Union’s reply brief. Therein, the County objected to the Union’s reference to the disposition of a parallel proceeding before the State of Wisconsin Bureau of Quality Assurance, with respect to the Grievant. On November 9, 2009, the Union

filed a brief in opposition to the County's motion. On December 10, 2009, I denied the Motion, noting that the parties had made a conscious decision not to include the findings of the Bureau of Quality Assurance in the record of the proceedings, though that determination existed and was available prior to hearing on this matter. I also indicated that I would not consider any references to the Bureau of Quality Assurance decision in this Award, and I have not done so.

This award addresses the discharge of the Grievant from the Grant County Orchard Manor Nursing Home ("Orchard Manor").

ISSUE

The parties stipulated to the following issue:

Did the employer violate Section 6.01 of the 2005 through 2007 collective bargaining agreement when it discharged [the Grievant], on December 20th, 2007? If so, what is the appropriate remedy?

RELEVANT PROVISIONS OF THE COLLECTIVE BARGAINING AGREEMENT

ARTICLE 6 - DISCIPLINE

6.01 The Employer shall not suspend, discharge or otherwise discipline any nonprobationary employee without just cause. When such action is taken against an employee, the employee will receive written notice of such action at the time it is taken, and a copy will be mailed to the Union within two (2) calendar days, except that written notice of oral discipline shall be given to the employee and the Union as soon as possible after the action is taken. Such notice shall include the primary reasons on which the Employer's action is based. In the administration of discipline, similar occurrences only shall be considered, and no such discipline which is more than one (1) year old shall be considered, unless it was a disciplinary suspension of one full shift or more, and then a two (2) year time limit shall apply. Similar occurrences are defined in separate categories of job performance and tardiness/absenteeism.

BACKGROUND

The Union and the County are the signatories to a collective bargaining agreement, the relevant portion of which is set forth above, that governs the wages, hours, terms and conditions of employment for the nursing assistants, dietary, housekeeping, laundry, maintenance, activity, and unit coordinator employees at Orchard Manor. The Grievant has worked as a certified nursing assistant ("CNA") at Orchard Manor since she was hired in 1999.

The Grievant's supervisor, Betty Winters, testified as follows on behalf of the Union, as to the Grievant's work performance:

Q: ..., how did you find her performance?

A: Good, very good. Like I say, she generally worked on the secured unit. I could go back there on rounds, and she would be scrubbing the floors, and she always kept the resident's room in tiptop shape. She cleaned drawers, and she did a good job with the residents. She did good peri care on them at night when they soiled, did their dentures, hairbrushes, always had them looking very good in the morning.

Winters testified that she was not consulted with regard to the decision to discharge the Grievant and she did not agree with the discharge of the Grievant.

The Grievant's performance evaluations since 1999 were made a part of the record in this proceeding. Those evaluations historically, on average, have rated her performance as "4" ("excellent performance") on a scale of "5" ("outstanding performance"). The Grievant's 2007 evaluation appears to be the weakest, in that it has more "3" ("meets performance standards") ratings than any other evaluation, but it has as many "4" and "5" ratings as it has ratings of "3". It is notable that the Grievant appears never to have received a rating of "1" ("does not meet performance expectations") or "2" ("needs to improve in meeting performance expectations") in any of the nearly twenty performance categories evaluated. Further, the Grievant appears never to have received a rating of lower than "4" in the performance category that evaluates whether an employee "maintains a safe, therapeutic environment by assisting in preventing accidents, injuries, and infections".¹

The Grievant's disciplinary history consists of three prior verbal warnings. The first was issued on March 21, 2006, and warns the Grievant that she had seven absences, which was characterized as excessive. On December 6, 2007, she was issued another verbal warning, which again indicated that she had seven absences, and again indicated the number to be excessive. On January 4, 2007, the Grievant was given a written warning, which was later reduced to a verbal warning, for the following incident:

... had a verbal outburst in the presence of several residents and two staff members. The verbal outburst consisted of an angry tone and used profane language including the "f-word" []. Residents and staff members should not be subjected to profanity at either their (staff) work place or in their (resident's) "home". ...

¹ The evaluation exhibits submitted for the Grievant's June of 1999 three-month evaluation and her October of 1999 six-month evaluation are both missing page two of the evaluation form. Thus, it cannot be said with certainty that the Grievant never has received a "1" or "2" rating or that she never has received below a "4" for the safe environment category, but that appears to be the case based on the other evaluations that were received into evidence.

The events giving rise to the Grievant's discharge occurred on December 16, 2007, between 6:00 a.m. and 6:39 a.m. The Grievant works the night shift at Orchard Manor, generally on the 600 wing and primarily on the secured unit. It is uncommon for her to work on the 500 wing, which is adjacent to the 600 wing. On December 16, she was working on the 500 wing. The Grievant's shift was scheduled to end at 6:30 a.m. At that hour, it is the responsibility of the CNAs to help the residents get up and prepare for the day. The process of waking the residents begins at 5:00 a.m. On December 16, the grievant was charged with the care of less than a half-dozen residents on the 500 wing, each of whom required assistance.

It is common for the CNAs on the night shift to do their charting between the time when they do their last bed check at 4:00 a.m. and start getting residents up at 5:00 a.m. The CNAs become busy after 5:00 a.m., and the charting is done in anticipation of the 6:30 a.m. end of shift. Although the charting frequently occurs before the end of the shift, it is expected that a chart would be corrected if it inaccurately reflects the resident's status by the conclusion of the shift.

On December 16, the Grievant filled in the resident charts before the residents were awakened at 5:00 a.m. As a part of that charting, the Grievant checked boxes indicating that a mobility monitor and a seatbelt were in use for L.B., the resident involved in the incident that led to the Grievant's discharge and, ultimately, this proceeding.

The record in this case characterizes L.B. as a resident with poor judgment, who does not understand the risk of standing up and who is unable to ambulate. The resident had a fractured hip, and the prosthesis had to be removed from her hip. She could not stand at all by herself, and she had a history of falls while attempting to get up by herself. L.B.'s diagnosis read as follows:

Alzheimer's Disease, Alzheimer's Dementia With Behavioral Disturbance, ... anxiety,... Depression,...Hypertension,... Osteoporosis,...Aftercare For Healing Traumatic Fracture Of Hip,...Care Involving Physical therapy,... Encounter For Change Of Surgical Wound Dressing.

L.B.'s "resident care plan" included an entry describing the basis for her care:

Impaired Mobility/potential for Falls/Potential for Altered Skin Integrity r/t hx. Of falls. Transfers with EZ stand to w/c. Uses w/c for mobility. Has soft belt restraint in w/c to prevent unassisted transfers and ambulation. Has a dx. of Alzheimer's Dementia and is unaware of the need for safety.

Certain approaches were mandated by L.B.'s resident care plan, including:

Transfers with EZ stand to reclining high back w/c

...

Uses w/c for mobility needs. Needs assist with getting to and from destinations.

...

L.B. was a small woman, who used a high-backed wheelchair equipped with a seatbelt. The belt served as a restraint to prevent her from unassisted transfers or ambulation. Her wheelchair was one of the few, if not the only, high-backed wheelchairs on the 500 wing of the facility. L.B. shared a room with another woman, who also uses a wheelchair. The roommate was a much larger woman, who used a much larger wheelchair, which was not equipped with a seatbelt.

Prior to the morning of December 16, the Grievant had cared for L.B. several times, but she only had gotten L.B. up in the morning on one occasion. On the morning of December 16, the Grievant had primary responsibility for L.B., among other residents on the 500 wing. The Grievant was assisted, however, by a co-worker, Wanita, who was assigned to work as a floater CNA that day. As the Grievant and Wanita were attending to L.B., they found two wheelchairs in L.B.'s room. One of the chairs they immediately recognized as belonging to L.B.'s roommate. As it turned out, both wheelchairs belonged to the roommate, but neither of the CNAs realized that at the time. They wondered if L.B. had gotten a new wheelchair, but both recognized that the chair they thought might have been the new wheelchair was "awful big" for L.B. They also recognized that it lacked a seatbelt. Both CNAs realized the resident needed a seatbelt. The CNAs spent ten to fifteen minutes trying various things to make the chair work for L.B., but ultimately realized they had to move on to attend to other responsibilities. The Grievant determined that L.B. would go into the large, unbelted chair.

Wanita suggested at the conclusion of this incident that they contact the nurse assigned to the wing to see if L.B. had been assigned a new wheelchair. The Grievant walked up the hall in the direction of the nurses' station. In the meantime, Wanita pushed L.B. to the dayroom. Wanita left L.B. there, facing a Christmas tree so she could enjoy it. Approximately ten minutes later, Wanita saw the Grievant again on the 600 wing. Wanita asked the Grievant if she had found out about the chair. It was Wanita's testimony that the Grievant replied that she had not seen a nurse and didn't know anything yet. The Grievant then headed up the hall.

After finishing her work on the 600 wing, Wanita returned to the 500 wing to check with the Grievant to see if she needed help. According to Wanita, the Grievant advised her that she had talked to someone and that the chair they had placed L.B. in was the roommate's chair. It was Wanita's testimony that the grievant indicated that "...they were trying her into another chair". Wanita understood this comment to mean that the matter had been taken care of.

Just before the Grievant's shift ended, the Grievant talked with another CNA, Krystal, who works the day-shift at Orchard Manor. Krystal was assigned to the 500 wing for the shift immediately following the Grievant's shift. The Grievant asked Krystal if L.B. was in the right chair. Krystal indicated that she was not, and she pointed to the right chair, which was in the day room. Following that conversation Krystal left the room, carrying two pieces of patient-transfer equipment, to attend to other residents.

All of these conversations occurred between 5:50 a.m. 6:39 a.m., when the Grievant punched out.

L.B. was subsequently found on the floor of the dayroom, having either slid or fallen out of the wheelchair. April, a registered nurse at the facility, was called to attend to her. April indicated that L.B. did not complain of pain. She noted a two-inch scratch on L.B.'s left arm and two red areas on her buttocks. In the days following the incident, L.B. showed increased signs of anxiety and agitation, and on December 19 she was returned to a behavioral facility where she had previously resided. There is no indication whether her return to that facility was related to her fall from the wheelchair.

The County was cited and fined \$1,000 for the incident involving L.B. Wanita was given a non-disciplinary notice referred to as a "letter of instruction – fair warning", instructing her that her action in placing L.B. into the wrong wheelchair was inappropriate. Krystal also was given a letter of instruction for her failure to follow through with her offer to assist the Grievant with L.B. after pointing out that L.B. needed to be in a different wheelchair. The Grievant initially was given a letter of instruction for having used the wrong wheelchair with no seat belt and no motion monitor. Upon further review, the incident was investigated by management at Orchard Manor, and the Grievant was terminated with the following letter:

DISCIPLINE – TERMINATION

TO: [The Grievant]
FROM: Angela K. Pierce, RN, BSN, DON
SUBJECT: Performance - Neglect
DATE: 12-20-07
CC: Union Local 3377 **Confidential**

On 12-16-07, you were involved in an incident at Orchard Manor where you neglected to follow the care plan to provide a resident with safety devices, (MD ordered restraint – seatbelt, and mobility monitor) to prevent falls. After being reminded by two different staff at three separate times, (approx. 6:00 am,

6:15 am and 6:25 am) you consciously and knowingly neglected to provide the resident with proper safety devices. You also falsely documented that you provided the devices. In addition, you left work without assuring the resident was safe and the resident fell within minutes of you leaving.

Your actions are unacceptable. This incident shows a complete disregard for resident safety and is considered neglect. You are hereby terminated based upon Orchard Manor Policy on zero tolerance for abuse and neglect, and State and Federal Regulations on neglect.

Per State and Federal definition: Neglect is defined as a failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness or the deterioration of a resident's physical or mental condition. Neglect is repeated conduct or a single incident of carelessness, which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

This incident was reported to the State of Wisconsin, Agency for Caregiver Misconduct.

PERSON ISSUING DISCIPLINE Angela K. Pierce, BSN, DON

SIGNATURE refused to sign

DATE 12-20-07

The Union introduced a number of instances of discipline involving matters related to treatment of residents. Of those placed in the record, the Union elicited testimony relative to the following:

- 1) In 2004, an employee was issued a verbal warning for transferring a resident with one instead of two people, as called for by the resident's care plan. Later that year the same employee was given a written warning for the same behavior.
- 2) In 2005, an employee was given a verbal warning for leaving a resident with a history of seizures in the whirlpool, for the purpose of getting people out of the resident center.
- 3) In 2006, an employee was given a verbal warning for failing to attach a mobility monitor to a resident or to place a bed alarm pressure pad on the bed. The resident fell, and no alarm sounded.

- 4) In 2000, an employee was given a verbal warning for using inappropriate language while attending to a resident. The same employee was given a written warning, in 2003, for "...using force during cares..." and, in doing so, injuring the eye of the resident involved. The warning was subsequently reduced to a verbal warning. In 2006, the same employee received a suspension under circumstances where "...the bed was not in the low position and the mat was not placed on the floor...". The employee left a resident in the bed in this position, and the resident fell and was seriously injured, suffering a fractured femur. The following month, the employee was given another suspension for failing to check on a resident who had been placed on the toilet. Having determined to undertake an investigation into the matter, management at the facility directed the employee to leave and he did so; but he returned thirty minutes later. He again was told to leave while the investigation was pending; and, contrary to that instruction, he returned again the next morning. His suspension was for not following the care plan and for insubordination.
- 5) In 2005, an employee was given a written reprimand for failing to attach a mobility monitor to a resident who fell.
- 6) In 2006, an employee was given a verbal warning for leaving a resident unattended on the commode for approximately two hours.
- 7) In 2006, an employee was given a verbal warning for transferring a resident without using a two assist. The resident slid to the floor during the improper transfer.
- 8) In 2006, an employee was given a verbal warning for leaving a resident unattended and unchecked on the toilet for approximately three hours.
- 9) In 2004, an employee was given a verbal warning for placing a resident on the toilet and failing to communicate that fact to other staff, causing the resident to remain on the toilet for several hours.
- 10) In 2004, an employee was given a written warning, later reduced to a verbal warning, for placing a resident in a Hoyer lift and beginning a transfer, without the assistance required by the care plan. After a second aide arrived, the resident slid out of the sling and received a bump on the head. In 2005, the same employee received a written warning for making an unassisted Hoyer transfer.
- 11) In 2005, an employee was given a verbal warning for leaving a resident on the toilet and failing to communicate that fact to co-workers.

- 12) In 2005, an employee was given a verbal warning for lifting a resident into bed, without using a mechanical lift, and for throwing the resident's clothes on the floor. (A second employee was also involved and was terminated as being the more culpable.)

- 13) In 1979, an employee was given a written warning for a variety of resident care shortcomings. In 1985, the same employee was given a written warning for an unexcused absence. In 1986, the employee was given a verbal warning for receiving personal visitors at work, and for leaving the facility without notice to her supervisor. Ten days later, the employee was given a verbal warning for excessive absenteeism. In 1990, the employee was given a warning, which was later modified to a "Fair Discussion", due to her inability to fulfill her job duties, evidently due to the employee's health. In 1994, the employee was given a verbal warning for failure to prepare a meal for a resident. In 1997, the same employee was given a verbal warning for a failure to report alleged abuse of a resident. In 2005, this same employee was given a "Fair Warning Education" because "...a resident with a history of multiple falls was found in bed at an unsafe height, no monitoring devices as specified in resident care plan. Bathing residents without soap...". In 2006, the same employee was given a written warning for two incidents: the first was for taking a resident to a classroom without her seatbelt fastened; the second was for leaving a resident unattended on the toilet for over one hour without being checked. One week later, the employee was given a suspension for two separate instances of leaving residents unattended on the toilet/commode for extended periods of time. In early 2007, the employee was given a suspension for covering instead of cleaning from the bed linens the vomit of a resident.

The testimony provided by Donna Haines, the administrator at Orchard Manor, relative to the various incidents set forth in the above numbered paragraphs, states as follows:²

REDIRECT EXAMINATION

By Mr. Finerty:

Q: Let's go through 28, and I'll just start out with –

A: We'll go in reverse.

² The excerpted portions of the transcript have been revised to include bracketed insertions that are intended to reference the numbered paragraphs set forth at pages seven through nine of this award.

Q: Yes, we'll go in reverse order. I will start out with a general question. Did all of these employees whose performance histories you have reviewed have the same disciplinary background?

A: No.

Q: Did they all have the same level of experience?

A: No.

Q: Did they all respond the same when they were confronted with an allegation of abuse or neglect?

A: No.

Q: Now, let's look at [13]. What differentiated this December 1st, 2005, incident in regard to [13]. Did she deny what had happened?

A: This is that – okay. You say it's for an unsafe height. Doesn't mean it was a low bed. It doesn't say that it actually could change the height.

Q: You specifically referred to the document attached to [13's] discipline? Just tell me –

A: These disciplines you can't take – you have to understand what the whole investigation proved. She denied this. There were no witnesses. There's no way of proving that. You know, we give them the discipline through the grievance process. That could have been overturned and wiped away. [13] would not admit to anything, and we could not catch her in the act, and so we had to go through the discipline process. She was not the most high performer. We did a lot of discipline trying to help her, and she did not – never had the opportunity to go back and correct. She – she just did not – she forgot. *I didn't do it. I forgot, whatever.* She would not – no one told her *Oh, [13], you forgot to, you know, go back and – you forgot to put the seat belt on.* I shouldn't say seat belt because it wasn't – well, the one was a seat belt, but she was with her, so she wasn't – she didn't leave her in unseated. The other person got her and took her to the classroom and then belted her, so this resident wasn't ever left alone with a seat belt un – she took her down the hall without it, but she was right there, and then when she went into the classroom, they attached the seat belt.

Q: Okay.

- A: And then [13] wasn't given the opportunity to correct or reminded to correct and corrected it.
- Q: So that differentiated it from the case of the grievant, correct?
- A: Yes. The vomit – he could – she could have cleaned him up and vomited again. It was unlikely, but we could not prove beyond – the investigation could not prove enough to terminate. You have to be able to prove it.
- Q: Again, that was different than what the investigation revealed in the case of the grievant?
- A: Yes. Two witnesses, had multiple opportunities to correct the situation and didn't.
- Q: Did the grievant deny what had happened?
- A: Yes.
- Q: In this – in [13] –
- A: In [13], yes, she would not admit and no witnesses.
- Q: What about the grievant in this case? Did she deny what happened?
- A: No. [The Grievant] said she didn't put the seat belt on, had her in the wrong wheelchair. She knew that, and she knew the care plan. She admitted she knew the care plan.
- Q: Let's look at [5]. Now again, why don't you explain for me the difference between a mobility monitor and a seat belt. Does the mobility monitor restrain the resident?
- A: No. The mobility monitor alarms when a person tries to get up or moves too far, and it's designed to try, if you're close to the resident, to get there before they actually fall. It doesn't prevent a fall. It alerts staff. If they're in the vicinity, they can try to get there sooner, but if you're in the next room, you can't. People do fall with them, but at least you can get to them right away, so they're not in discomfort very long, you know, if they had fallen. A seat belt, if it's a restraint – we have several residents with a seat belt but that aren't a restraint, and the difference is if the resident can take off the seat belt, then it's not a restraint, but in L.B.'s case, she was not able to put it – take the seat belt off, and it was considered a restraint and it prevented her from falling. That was the purpose of it.

Q: What did the investigation reveal in the case of the grievant with regard to the seat belt and the mobility monitor?

A: [The Grievant] failed to put it on after she was reminded three different times that it should have been on, and she knew it should have been on but chose to ignore the care plan.

Q: In fact, she charted that it was on, correct?

A: Yes.

Q: So in all these incidents that you went through with Mr. Rainford, are you comparing apples to apples?

A: No. I think in [4's] case, there's a lot of information that's not present in these disciplines.

Q: Mr. Rainford didn't show you the entire disciplinary history in some of these cases, did he?

A: No, but even some of these disciplines, especially the last – the last suspension, the repeat suspension for seven days, [4] was kind of set up. We had a state surveyor in and a federal surveyor, and he was watching [4] and just waiting for him to make a mistake, and he was ordered by his supervisor to go help another staff and took him away from the resident that was in the – and the surveyor watched the resident basically at the door to make sure some – it wasn't a fair – [4] did wrong for not telling someone, but it wasn't – he didn't have complete control over the situation.

Q: Now, is there a comparison you can make with the grievant? Is it the same thing that the grievant –

A: She had the opportunity at 6:00 to find the nurse. There were nurses available. The situation didn't start until 6:20 with the critical incident, so there were nurses available at that point. She had talked to Krystal earlier. She could have asked her at that point. She waited until near the end of the shift to ask her. Then she was reminded by Wanita two different times, and the first time she hadn't found out the information yet. The second time she did know the information. She was right next door to the – right across, kitty-corner from the day room and [another resident's] room at the end of the shift. They could have easily taken the equipment across the hall and moved her into the right chair.

Q: So as you see all these incidents in isolation perhaps over the course of a month or a year, in your mind when you review them on the day of the discharge, were they the same? Could you make a direct comparison?

A: No. These were – each one was more of an isolated, you know – and people do make mistakes, but as far as, you know, one mistake. They forget a person because there's a lot of things going on, which is unfortunate, but it happens, but when you're reminded and then you don't do it and then you're reminded again and ignore it, and that's her obligation as a CNA to make sure she's restrained, in this case, with, you know, a very unique, you know, restraint, which isn't a common practice and –

Q: Let's find one of these I want to look at here. Let's take the example of [10].

A: Okay.

Q: Now, let's just get a little background on how the grievant responded to the investigation in this case. Again, we talked about it a little bit, and I don't want to belabor the point, but how did the grievant respond in this case to this investigation?

A: She said to be honestly, truthfully I never thought –

Q: Let's talk about the grievant first. How did she respond to the investigation in this case?

A: She blamed everyone else.

Q: Who did she blame?

A: She blamed Krystal initially and Wanita, that they were aware and that they should have done it for her even though she was responsible for getting her up and in a safe condition before she left.

Q: How did that differentiate from –

MR. RAINFORD: I'm going to object to the question and the response. Look, the grievant spoke for herself in two statements that are part of the record, and the administrator isn't characterizing her testimony regarding this situation through those statements accurately at all.

MR. FINERTY: I will make my point quickly, and if you feel it's not relevant, then I would say that you don't have to consider it.

ARBITRATOR CARNE: I'll overrule it. Go ahead.

Q: How did the grievant's response to the investigation compare with, for example, [10's] response in regard to the April 8th, 2005, incident?

A: She was very remorseful and sorry as most of them. You know, [4] also was just devastated by the fall, and most of the employees that we have that get disciplined are very upset for the – and very concerned for the resident. Let's see which one?

Q: Okay.

A: Especially [8]. This practically devastated her. She was crying. She just made herself ill on thinking that she would have forgotten something like that. She said she was so concerned with the resident or her group of residents. She was so concerned.

...

Q: Again, just to show you the isolation here, you mentioned something else regarding [12]. Was [12] one of the employees who was disciplined for this incident?

A: Yes.

Q: What was [12's] disciplinary history?

A: I don't think she had any other disciplines that I can recall.

Q: Do you recall the name of the other employee who was disciplined, if you can?

A: I cannot.

Q: Do you recall if that other employee whose name you can't remember was terminated?

A: She was. She was in a probationary period, and she was not doing a good job. She was the one that did throw the clothes on the floor. It was not [12].

MR. FINERTY: That's all I have.

. . .

The Grievant did not testify in the proceeding.

DISCUSSION

I believe the Grievant knew the wheelchair was not the right chair for L.B. All evidence supports that conclusion. Her co-worker, Wanita, understood it to be the wrong chair. The two talked about it and were frustrated as they spent ten to fifteen minutes on the morning of December 16 trying to make adjustments to make the wheelchair fit L.B. There is a significant difference between the size of the chair that would have fit L.B. and the size of the chair that would have fit her much larger roommate, and to an experienced caregiver such as the Grievant that difference would have been obvious. Furthermore, the Grievant had charted that a seatbelt restraint was in place with regard to L.B. Having made that note only an hour or so before she assisted L.B., the Grievant had notice that L.B. required a belt, notwithstanding the fact that the Grievant had spent little time with this particular resident. I believe that the Grievant initially was surprised and confused to find two large wheelchairs in L.B.'s room. At some point, however, by the end of the shift, and certainly following the Grievant's exchange with Krystal, that confusion should have cleared.

It is unclear exactly what the Grievant was doing at the time when she ostensibly went to ask about L.B.'s chair. Although I am not willing to draw the negative inferences proposed by the County from the fact that the Grievant did not testify at the arbitration hearing, by not providing testimony the Grievant missed an opportunity to explain what occurred during this period of time. In any case, there is no persuasive evidence in the record to support a conclusion that anyone else had taken on the task of transferring L.B. to the appropriate chair. Further, the fact that the Grievant did not have help at the end of the shift is relevant, but it does not excuse the Grievant's decision to leave the facility without attending to the wheelchair issue.

In the end, the Grievant knowingly placed L.B. in the wrong chair, left her there unbelted for a period of thirty to forty minutes, and left work with L.B. still in the wrong chair. I agree with the County that the Grievant's lapse in judgment was disciplinable behavior. The question in this case is whether discharge was the appropriate level of discipline.

The parties agree that the Grievant's work history is relevant. They focus on different aspects of that work history and come to different conclusions. The Grievant is an eight year employee. According to the testimony of her immediate supervisor, who was not consulted in the course of the disciplinary investigation, the Grievant was also a very good employee. That assessment is affirmed by the largely positive annual performance evaluations the Grievant received over the entire course of her employment. One of the performance categories evaluates whether an employee "maintains a safe, therapeutic environment by assisting in

preventing accidents, injuries, and infections.” The Grievant consistently earned a “4” (“excellent”) rating in this category. Thus, the record portrays the Grievant as an employee with a strong track record of attention and sensitivity to the safety needs of the residents.

The Grievant has a discipline history. She has three verbal warnings in her file. Two of those warnings were for attendance-related matters, and I do not regard them as related to the matter at hand. The third warning was for a verbal outburst that included profanity. While offensive to residents and staff, and perhaps a form of abuse, that type of conduct is simply different from that in question here. What is at play here is the level of attention to the safety-related needs of a resident and the Grievant’s awareness and judgment relative to resident care needs. Overall, I view the Grievant’s disciplinary history as modest and not particularly related to the conduct at issue in this proceeding. That being the case, I do not regard the disciplinary action in this case as constituting a terminal step in a progressive sequence.

It is the view of the County that, given the asserted gravity of the Grievant’s conduct, particularly with the repeated opportunities she had to correct the situation, no progressive discipline was required. That contention takes on context by viewing it in light of the discipline the employer has imposed under the varying circumstances it has faced concerning employees of Orchard Manor.

Many of the incidents cited to the record in this case do not rise to the level of the conduct in this matter, but some do. Some of the incidents include similar conduct to that which formed the basis for the Grievant’s discipline. The employees discussed above in paragraphs three, five, and thirteen involved incidents where no monitor was placed on the resident. Those incidents resulted in a verbal warning, a written warning, and a “fair warning education”. Further, some of the cited conduct appears to be on par with the Grievant’s conduct, in that it set the stage for resident injury in the same way the Grievant’s conduct did. The employee discussed in paragraph two left a resident with a history of seizures in a whirlpool unattended. A verbal warning was issued to that employee. The employee discussed in paragraph four left a resident’s bed in too high a position, without a mat on the floor. The resident fell and suffered a fractured femur, and the employee was given a suspension. The employee discussed in paragraph thirteen was given a verbal warning for failure to report alleged abuse of a resident. This same employee was given a “fair warning education” for leaving a resident, with a history of falls, in bed at an unsafe height without the required monitoring devices. The employee was subsequently given a written warning for taking a resident to a classroom without a seatbelt. In each of these instances the employee demonstrated poor judgment relative to the safety needs of the resident. In each of these incidents, the employee placed a resident at risk of harm. Some of the instances resulted in actual harm. What is striking is that all of the incidents led to warnings, with the exception of the suspension issued to the repeat offender.

In a number of instances the level of discipline was reduced, in apparent recognition of the need to apply discipline in a progressive fashion. Also notable about the disciplines cited in these prior matters is the fact that not one of the single incidents resulted in termination. There

were employees terminated, but only following a series of disciplines. In many of those matters the employer acknowledged that the employees made a mistake or were in the midst of a busy or hectic workday. The reality of the workplace tempered the discipline. In this case, the Grievant was in the midst of a busy work period. Furthermore, her mistake appears to have been a departure from an otherwise very strong work record, particularly in the safety area. It does not appear that those factors were given as much consideration with regard to the Grievant as in other instances.

The County insists that this matter is unique and distinguishable from those that have gone before it because the Grievant was given a number of opportunities to correct the fact that L.B. was placed in the wrong chair. The problem with this contention is that the record is silent as to how many opportunities the other employees who received lighter disciplines had, as their events unfolded, to correct their errors. When a resident is left on a toilet for hours, it is unlikely that such opportunities were not presented. The time frame for the Grievant's actions spanned, at most, forty-five minutes. Further, in a longer-range sense, the Grievant was deprived of the opportunities other employees have been afforded to correct her behavior. There are a number of employees referenced in this proceeding who have been told explicitly that their behavior was inappropriate and would have to change. Those employees were warned formally. The employer has used progressive discipline to warn employees not to exhibit certain behaviors, only to see those behaviors recur. The employees referenced in paragraphs one, four, and thirteen were the recipients of progressive discipline. When similar behaviors followed the issuance of a warning, progressive measures were used, giving the employees ample opportunity to correct deficiencies. There is no reason to believe that progressive discipline would not be effective here.

The County points to an unwillingness on the Grievant's part to accept responsibility or to exhibit contrition as a meaningful dimension of the disciplinary action at issue in this case. I agree generally that that is a relevant consideration. It should be noted that this contention is not the same as saying that the Grievant refused to admit wrongdoing. Haines' testimony established that one of the reasons the County was able to discipline the Grievant was because she admitted wrongdoing, as opposed to instances involving other employees who would not admit anything and, therefore, could not be disciplined because nothing could be proven. Here, the Grievant did not deny that the incident involving L.B. occurred. The issue in this case is her effort, when confronted, to suggest that the others involved in the incident should bear some or all of the blame for it. It is certainly fair for the employer here to want to discourage finger-pointing, particularly in this situation where the Grievant was assigned to and primarily responsible for the resident. Under the circumstances of this case, however, such defensive behavior was not a sufficient basis for ignoring the progression of discipline historically used at Orchard Manor. Again, the Grievant is an employee with a strong record of attention to the safety of residents, and this act appears to have been out of character for her.

Finally, I do not regard the failure to correct the chart as anything more than an omission. It was the uncontradicted testimony of the Grievant's former supervisor that it was common to chart before the end of the shift. Winters went on to testify that there is an

expectation that charts will be corrected if appropriate. She further testified, however, that there never has been discipline issued for a failure to correct an inaccurate chart. It appears to me that the Grievant was ready to go home, after a busy end of the shift. That fact does not excuse her conduct, but there is no evidence to support a conclusion that there was a conscious decision to mask inappropriate behavior with a doctored chart entry.

AWARD

The grievance is sustained.

REMEDY

The County is directed to reinstate the Grievant, and to make her whole for losses in pay, benefits, and seniority. The County is entitled to offset the backpay with unemployment compensation benefits or interim earnings, if any. The County is free to issue a written warning relative to the incident that led to the discharge.

JURISDICTION

I will retain jurisdiction for a period of sixty (60) days from the date of this award, to address any dispute as to remedy.

Dated at Madison, Wisconsin, this 10th day of August, 2010.

Danielle L. Carne /s/

Danielle L. Carne, Arbitrator

DLC/gjc
7605