BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

BREWSTER VILLAGE EMPLOYEES UNION, LOCAL 980
affiliated with the
WISCONSIN COUNCIL OF COUNTY AND MUNICIPAL EMPLOYEES, AFSCME, AFL-CIO

and

COUNTY OF OUTAGAMIE, WISCONSIN

Case 303
No. 70203
MA-14899

Appearances:

David A. Dorn, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 336 Doty Street, Fond du Lac, Wisconsin 54935, for Brewster Village Employees Union, Local 980, affiliated with the Wisconsin Council of County and Municipal Employees, AFSCME, AFL-CIO, which is referred to below as the Union.

James R. Macy with **Chad P. Wade,** Davis & Kuelthau, S.C., Attorneys at Law, 219 Washington Avenue, P.O. Box 1278, Oshkosh, Wisconsin 54902-1278, appearing on behalf of County of Outagamie, Wisconsin, referred to below as the Employer or as the County.

ARBITRATION AWARD

The Union and the County are parties to a collective bargaining agreement, which was in effect at all times relevant to this proceeding and which provides for final and binding arbitration. The Employer and the Union jointly requested that the Wisconsin Employment Relations Commission appoint Richard B. McLaughlin, a member of its staff, to serve as arbitrator to resolve Grievance CB 007-515, filed on behalf of Ramiro Garza, who is referred to below as the Grievant. Hearing was held on December 8, 2010, in Appleton, Wisconsin (references to dates are to 2010, unless otherwise noted). Kathryn A. Smits filed a transcript of the hearing with the Commission on December 20. The parties filed briefs and reply briefs by March 9, 2011.

ISSUE

The parties were unable to stipulate the issue for decision. The County states the issues thus:

1. Did the County have just cause to terminate the Grievant?
2. If not, what is the appropriate remedy?

The Union states the issue thus:

> Did the County violate the Collective Bargaining Agreement by terminating Ramiro Garza's employment?

In my view, the record poses the following issues:

> Did the Employer have proper cause to discharge the Grievant?
>
> If not, what is the appropriate remedy?

RELEVANT CONTRACT PROVISIONS

ARTICLE I - MANAGEMENT RIGHTS

1.01 - Unless otherwise provided herein, the management of the work and the direction of the working forces, including the right to . . . suspend, or otherwise discharge for proper cause . . . is vested exclusively in the Employer.

1.02 - The Employer shall adopt and publish reasonable rules which may be amended from time to time. . . .

1.03 - Action to amend or alter or otherwise change said rules and regulations shall be subject to the grievance procedure in this Agreement. If any action taken by the Employer is proven not to be justified, the employee shall receive all wages and benefits due him/her for such period of time involved in the matter. . . .

ARTICLE XXVIII - DISCIPLINARY PROCEDURE

28.01 - The following disciplinary procedure is intended as a legitimate management device to inform employees of work habits, etc., which are not consistent with the aims of the Employer's public function, and thereby to correct those deficiencies.

28.02 - Any employee may be demoted, suspended or discharged for just cause. As a general rule, the sequence of disciplinary action shall be: Oral reprimands, written reprimands, suspension and discharge. . . . Except for resident care warnings, no valid warning shall be considered effective for longer than a twelve (12) month period of employment.

28.03 - The above sequence of disciplinary action shall not apply in cases which are cause for immediate suspension or discharge. For example: theft of personal or public property, drinking on the job, drunk on the job and any violation of Section 940.295 are hereby defined as cause for immediate discharge, and gross negligence or willful dereliction of duty or violation of the grievance procedure are hereby defined to be immediate cause for suspension. . . .

28.05 - . . . Suspension shall not be for less than two (2) days, but for serious offense or repeated violations suspension may be more severe. No suspension shall exceed thirty (30) calendar days.

BACKGROUND

Grievance CB 007-515 challenges whether the County had just cause to discharge the Grievant. As of his discharge, the Grievant had worked for Brewster Village (the Village) as a Certified Nursing Assistant (CNA) for roughly twelve years. He served as the Union's Vice President for roughly six years.

The Village is a 204 bed, licensed skilled care nursing facility. It provides nursing care to long-term and short-term residents. Long-term residents pose care issues ranging over general weakness, dementia, chronic mental illness and developmental disability. The Village structures itself to provide care through a Neighborhood and a Household. A Neighborhood includes roughly forty residents, and a Household is the Village's smallest structural division. Direct patient care is structured from a medical care plan, which is a formal guide to implement medical diagnosis through to daily activity. A care plan can include baselines, which state specific daily directives to a CNA. CNA performance of a baseline, which can range from charting requirements to resident daily activities or physician's directives, is recorded onto a resident's chart. Neighborhood Managers, physicians or nurses can create a baseline. Village care plans and their component parts are maintained on computers. Changes to care plans, including baselines, are discussed at shift reports, which take place between shifts, involving caregivers responsible for the same group of residents.

Catherine Knifke is a Registered Nurse and the Neighborhood Manager for Heron Pointe of the Village. R is an elderly, long-term resident of Heron Pointe. The Grievant had primary care responsibility for R in March and April. The Grievant worked the first shift, which runs from 6:30 a.m. through 2:30 p.m. Knifke was the Grievant's supervisor.

In October of 2009, R experienced shortness of breath and manifested a dusky skin color. Knifke and R's care team administered oxygen to maintain a sufficient oxygen saturation level in his bloodstream to permit him to function. Knifke reported the matter to R's physician. After review of the incident, his physician prescribed oxygen "around the clock." Oxygen administration was necessary to assist R's heart functioning. In its absence, R's heart functioned at a level that risked congestive heart failure.

R's oxygen administration requires separate tanks, one large (the canister) and one smaller (the portable). The canister remains in R's room. R accesses this tank while in bed. R wears the portable while active. His level of activity affects his oxygen requirements, but his care plan calls for him to receive two liters of oxygen per minute. Under normal circumstances, this requirement means that the portable contains no more than eight hours' supply. R arises from bed around 6:00 a.m. The Grievant was responsible for taking R off of the canister and hooking him to the portable.

The Village maintains an oxygen fill room that contains a large tank from which portables are filled. There is a sign-in log by the large tank, which is to be initialed by the employee who fills a portable. The log is a spreadsheet type of document, with one spreadsheet for each month of the year. Each spreadsheet contains a row for each resident and a column for each day of the week of each month. Above the oxygen tank in the oxygen fill room is a placard which details, by the amount of oxygen prescribed, how long a portable can be expected to last.

R's sister visited him regularly, typically in the afternoon between 2:30 and 3:00 p.m. She approached Knifke to complain that in spite of her complaints to staff, R was running out of oxygen during her visits with him. Knifke responded by writing Baseline 7 to assure compliance with the physician's order for around the clock oxygen. Knifke implemented Baseline 7 effective March 28. Baseline 7 states:

> BASELINE 7: Staff are to check and fill portable O2 between 2pm-2:30pm each day.
> KEY:
> Y=Yes
> N=No
> N/A=Not applicable

The chart, on which a CNA would document compliance with Baseline 7, is a spreadsheet type of record, consisting of row and columns. Baseline 7 of that chart states a row for the initials of a CNA providing care for R, and another row for a specific response, which is what follows the "KEY" reference noted above. For the time period at issue here, the two first shift CNAs responsible for completing this portion of R's chart were the Grievant and Sue Ryberg. Ryberg worked the first shift on days the Grievant was off.

The discharge focuses on the Grievant's compliance with Baseline 7. Chad MacKenzie is the Village's Director of Nursing and was responsible for the discharge decision. He documented the decision in a letter to the Grievant dated May 10, which states:

> Effective April 26, 2010, your employment with Brewster Village is terminated due to Falsification of Records and Dishonesty. The decision to terminate your employment is based on the result of a recent investigation at Brewster Village as follows:

> A baseline to check and fill a villager's oxygen tank was initiated on March 28, 2010. It was necessary to initiate this baseline because a family member of the villager, who visits each day, voiced a concern that the villager's oxygen tank was consistently empty upon her arrival between 2:00 pm and 3:00 pm each day. The villager was placed on oxygen via a MD order on October 5, 2009 for congestive heart failure and shortness of breath following an exacerbation of symptoms on October 4, 2009. The villager is at greater risk when exerting self, but continuous oxygen at 2L/minute has been effective in minimizing symptoms. It is essential that the villager receive his continuous oxygen.
>
> The same family member voiced a concern on April 20, 2010 that the oxygen tank was empty again, which led to an investigation of why the oxygen tank was not filled. It was discovered, through your admission, that the record as it related to the villager's oxygen was falsified on the following dates in 2010; March 29, March 30, April 4, April 6, April 7, April 13, April 17, April 18, April 20. You stated that you take full credit and that you made a mistake by not checking and charting that you did. You went on to say that you just assumed the tank would be full enough to make it into the next shift since it should last approximately eight hours.
>
> The investigation also revealed that you were not forthright with your statements. On April 21, 2010 you stated that you thought the baseline was only in place to make sure the oxygen tank was checked and that if it was "full enough" it did not need to be filled. Your claim was that you checked the oxygen and signed that the tank was checked. On April 23, 2010 you were provided information that proved that the tanks were not checked by you. You, subsequently, admitted to not checking the tank and documenting that the tank was checked. This substantiated that you were dishonest during the investigation. The falsification of records and dishonesty put a villager in your care at risk. . . .

The balance of the **BACKGROUND** is best set forth as an overview of witness testimony.

Chad MacKenzie

Mackenzie has worked for the Village for roughly four years. As a licensed facility, the Village is audited annually and more often if complaints are filed. Audits review a facility's implementation of physician orders through an individual care plan. Staff training is a significant part of the implementation process. The Grievant, as other CNAs, has received training, including specific in-service training on oxygen delivery. In MacKenzie's view, R's need for oxygen on an ongoing basis was discussed at shift reports, covered in training, and detailed in the placard in the oxygen fill room.

This general notice was the background to the creation of Baseline 7, which traced to two different complaints from R's sister that R's oxygen ran out during her visits. Implementation of Baseline 7 demanded that nurses advise CNAs during shift report that the portable had to be checked for proper operation and filled not later than 2:00 p.m. through 2:30 p.m. MacKenzie understood that nursing staff explained Baseline 7 to CNAs, making clear that the portable had to be filled between those hours, unless it was less than one-quarter empty. Given the level of oxygen prescribed for R, it was certain that Baseline 7 required R's portable to be filled late in the first shift. In spite of this, on April 15, R's sister again complained that R's portable was not filled during the first shift. This complaint was communicated by a nurse to the Grievant.

On April 20, Knifke informed MacKenzie that R's sister had again complained that the portable was empty before the end of first shift. MacKenzie responded by phoning the Grievant. MacKenzie summarized the Grievant's response thus:

> I told him that there was a family complaint and his response was, it's probably about R's oxygen and he stated that I wanted to -- I was gonna come in the next day -- let me think about this. He stated that he knew that he had forgot to check and fill the oxygen at that point and was gonna come in and change his documentation in the morning to reflect that. [Transcript (Tr.) at 29-30]

At this point, MacKenzie determined that a formal investigation was necessary. The investigation included meetings on April 21 and 23. It also included his review of the oxygen logs, Baseline 7 charting and R's "24-Hour Report" forms starting with March 28.

The April 21 meeting included MacKenzie, Amanda Springstroh, the Grievant and his Union representative, Dawn Gustafson. MacKenzie started the meeting by discussing the April 20 phone call. The Grievant affirmed his response. MacKenzie's notes read thus:

> He said that his portable should have been filled but when R was not there, "he skipped it". He also says he has been trying to work on a plan of action to make sure the portable oxygen was full. He said he was trying to do it while taking the garbage down. Dawn states when (the Grievant) is not there she fills the oxygen. Then she said; "The more I think about that, I probably shouldn't because Sue is the one signing it out. It probably is not a good idea if she is documenting."
>
> (The Grievant) stated that it says to check oxygen and he thought it meant to only fill if it was close to empty. He said that he would not fill it if there was "an hour or two left." Asked him how he could tell and he stated you can guesstimate by looking at the gauge. He said that he has filled the portable oxygen for R "4, 5 or 6 times in the past month. He also said that all of his initials were prior to 2 pm because the charting helps to remind him to check the tank.

> He also expressed that he completed his charting before 2 pm because things can happen during the shift and he may not be able to get back into chart because of time constraints. I explained that it would be the same time constraint that may make it difficult to go back in and change charting.
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> (The Grievant) acknowledged that he has been talked to regarding the portable oxygen tank for R. He said it was reviewed a couple times as a group, Amanda talked to him and he is sure Cathy did as well. (The Grievant) contends that his documentation of yes on the baseline is stating that he has checked the tank and it is full enough to go into the next shift.
>
> (The Grievant) was asked how many times in the past week he had filled the portable oxygen. He stated he wasn't sure, but maybe once. He said; "There is a log in the O2 room and I sign it every time that I do it." He then stated that many times it is not filled when he comes on his shift and he has to fill it. He said; I just had two fills last week." I then asked him why he couldn't recall how many times he filled in the past week and he wasn't sure, but then was confident he filled it twice in the past week. He said he didn't know what to tell me. He said he was not going to keep answering the same questions. "This is what you did last time and made it seem like I was being dishonest. I explained that I needed to ask similar questions because there were inconsistencies and that refusing to answer my questions would not help him.
>
> After this he did not answer questions openly. He said he could not explain why he said he may have filled once in past week, but then knew for a fact he filled it twice in the past week. He also does not know why the 02 log does not reflect what he is saying. (The Grievant) was informed that the investigation is ongoing and that he should be prepared to report to work at anytime, but not to report unless called. He then left the room. . . .

After the interview, MacKenzie, Gustafson and the Grievant went to the oxygen fill room. MacKenzie pointed out the documentation above the tank and pointed out that the portable contained roughly eight hours' supply of oxygen. Mackenzie reviewed R's typical time to go to sleep and to arise, then, "pointed out that this was more than 8 hours and would require at a minimum 2 fills per day." His notes document the Grievant's response thus: "(He) responded; 'At least two.'" After MacKenzie noted that the oxygen logs consistently showed only one initial per day, the Grievant responded to the effect that, "it looks like a problem you will have to look at for all shifts."

After the meeting, MacKenzie reviewed the oxygen logs, Baseline 7 charting and R's "24-Hour Report" forms, starting with March 28. He concluded that the Grievant had entered "Y" on R's Baseline 7 charting for March 30; April 3; April 4; April 6; April 7; April 13; April 14; April 17; April 18; and April 20. March 30 posed an issue because the 24-Hour

Report showed the portable was empty at 2:30 p.m. April 3 posed an issue because the oxygen log showed the portable had been filled by second shift personnel. April 4 posed an issue because the 24-Hour Report showed R was out of the facility until well into the second shift. April 6 posed an issue because the 24-Hour Report showed the portable was empty at 2:30 p.m. April 7 posed an issue because the 24-Hour Report showed the portable was empty at 2:00 p.m. April 13 posed an issue because the 24-Hour Report showed the portable was empty at 2:00 p.m. April 14 posed an issue because the 24-Hour Report showed the portable was filled by second shift personnel. April 17 posed an issue because R's sister complained that the portable was filled by second shift personnel. April 18 posed an issue because the 24-Hour Report and the oxygen log showed the portable was filled at 2:30 p.m., by someone other than the Grievant. April 20 posed an issue because the 24-Hour Report and the oxygen log showed the portable was filled by second shift personnel.

MacKenzie then called the meeting of April 23. He met with the Grievant, who was represented by a different Union representative. The meeting involved detailed discussion of MacKenzie's review of R's chart. He testified that the Grievant responded thus:

> Well, the Grievant continued to state that he felt that he only needed to check the oxygen at that point. And it wasn't until I started naming off the specific dates that contradicted that, once I did that the Grievant said -- he was apologetic. He made a mistake. But he did not, he did not check and fill the oxygen. (Tr. at 40).

MacKenzie's notes document the Grievant's responses thus:

> (The Grievant) was asked if he recalled the meeting he had with Amanda Springstroh, RN on April 18, 2010. He said what he remembered was that everyone was suppose to keep an eye on Ronnie's oxygen. They needed to "make sure it gets checked and filled." Then stated; "If it was empty." He said he would only fill it if there was not enough to go into the next shift. He also said that they knew it was a problem because (R's sister) was upset and that was a problem. (The Grievant) was asked why the baseline would be initiated to just check the oxygen if they knew (R's sister) comes in each day around 2:30. (The Grievant) stated that it was his misunderstanding the baseline. (The Grievant) was informed that on April 18, 2010, the baseline was reviewed with him and Sara Hill. He was informed that Sara's recollection of the meeting was that they were to make sure the oxygen was filled so it was full for the next shift. He was also informed that on April 19, 2010 the purpose of the baseline was reviewed with Sue Ryberg and Dawn Gustafson and they both recalled the same as did Sara Hill. . . .
>
> The following dates and signatures were reviewed and pointed out that he initialed that he had "checked" the oxygen and it was noted that oxygen had to be filled by the PM shift between 2:30 pm and 3 pm; 3/30, 4/6, 4/7, 4/13, 4/14, 4/17, 4/18, 4/20.

> The following dates and signatures were reviewed and pointed out that he initialed that he had "checked" the oxygen and it was noted that the resident was not in the facility; 3/29, 4/4. (The Grievant) was asked how these signatures were valid. He stated; "I would say they are not. I take full credit for all of them except the ones that were around 3 o'clock." It was explained to (the Grievant) that the only one at 3 o'clock was the one that was reported to the PM staff RN and that there was documentation that a PM nursing assistant filled the oxygen on that date at 3 pm. He then stated; "I made a mistake and I am admitting to that. I am apologetic." He was asked what the mistake was to which he responded; "Charting when it was not checked." He assumed that it would be full enough because it was full when we put it on R and it is suppose to last around 8 hours . . .

MacKenzie concluded the responses confirmed falsification of records.

After the interviews, MacKenzie reviewed the Grievant's personnel file, which includes a disciplinary suspension on April 8 and 9, 2009 "for violation of the Outagamie County Work Rules and Conditions of Employment or the Brewster Village Administrative Procedures, specifically dishonesty."

On January 25, the parties executed a "Grievance Settlement Agreement" including the suspension noted above. The agreement states:

> The verbal warning . . . and the suspension . . . shall be treated as if they occurred 12 months prior to today. As such, neither of those disciplines will be used against (the Grievant) in the future for progressive discipline purposes.

After his review of the Grievant's personnel file, MacKenzie concluded that the misconduct regarding R's oxygen administration warranted discharge.

MacKenzie acknowledged that Ryberg completed Baseline 7 on a series of dates in which her initials do not appear on the oxygen log. These dates do not include March 28, where she noted "OOF" on Baseline 7 to indicate R was "out of the facility." He did not discipline Ryberg because he could find no documentation that R's portable was empty or was filled by second shift personnel on any of the dates she inserted a "Y" response on Baseline 7. MacKenzie interviewed other CNAs involved in R's care and found none who read Baseline 7 to mean something other than that R's portable should be full prior to the start of second shift.

Catherine Knifke

Knifke has worked for the Village for roughly twenty-one years. Knifke addressed R's oxygen administration when it was changed to "around the clock". At this point, R's entire care team would have been advised of the need for R to have oxygen continuously as well as of

the need to check the operation of the portable, and to fill it as needed. The instructions also would have included notice that the portable had an eight hour capacity. These instructions were broad, covered all shifts, and probably took place at shift report.

R's sister's complaints prompted her creation of Baseline 7. It did not stop the complaints. As a result, Knifke met in her office with Heron Pointe first and second shift caregivers to explain the need to keep R's portable full. She detailed R's sister's concerns regarding the empty portable and explained the need to keep it full as directed by Baseline 7. She did not feel it was possible the Grievant could have misunderstood that "check and fill" meant something other than assure the portable was operational and full prior to second shift.

In spite of this, Springstroh informed Knifke that R's sister and second shift staff had informed her that R's portable was empty and had to be filled by second shift personnel. This occurred prior to April 20. Knifke's notes, dated April 21, document events on April 20 thus:

> (R's) sister . . . came to me on 4/20/10 upset and frustrated and wanted to speak with me. She stated that she continues to come and get R and the 02 tank is not filled. She stated that maybe 1 or 2 times within the last month it has been filled. She was informed that I had implemented the baseline to help avoid further issues and that I would check into the matter. She stated when she came upstairs to get his 02 filled that she had passed by (the Grievant) in the hallway and he said to a peer he was walking with the following: "I hope that R's 02 tank is filled". (The Grievant) was speaking loud enough for (her) to overhear.
>
> I then contacted Chad Mackenzie RN DON to investigate appropriate action that could be taken in this matter. . . .

In Knifke's experience, the Village discharged an LPN who charted that she performed a treatment procedure that she had not performed. The matter occurred many years ago, and was the only instance of that type she could recall. The matter was not grieved.

Amanda Springstroh

Springstroh was, as of the hearing, a Neighborhood Manager, but was a Primary Care Nurse in April. On Thursday, April 15, a second shift CNA complained that R's portable had to be filled at 2:30 p.m. The Grievant was not scheduled to work until Saturday, April 17. On April 17, Springstroh spoke with CNAs at a shift report between third and first shift. The Grievant was one of the CNAs at that shift report. During the report, Springstroh emphasized the need to keep R's oxygen continuously available to him, and emphasized that the portable only contained about eight hours of oxygen, thus necessitating an oxygen fill prior to the start of second shift. Springstroh had no doubt that each CNA understood that Baseline 7 required R's portable be filled prior to the start of the second shift.

Springstroh learned on Sunday morning, April 18, that R's portable had not been filled prior to the start of the second shift the prior afternoon. She spoke with the Grievant and another employee at Noon on April 18. Her notes of that conversation read thus:

> I discussed with him and Sara Hill who was present during our conversation that on 2L/Min the oxygen tank only lasts 8 hours, therefore it always will need to be filled prior to am shift leaving. I then discussed that if we are truly a team that if (the Grievant) is busy around 2:00 p.m. ie collecting trash etc. then Sara could fill the oxygen tank etc. They both agreed. . . .

Springstroh did not believe the Grievant could have understood Baseline 7 or her direct conversations with his team or with him to permit the Grievant to check R's portable and leave it only partially filled for the second shift to fill when it became empty. The "check" portion of Baseline 7 did not mean "check" whether the portable had any oxygen, but "check" whether the portable was functioning. The "fill" requirement was a stand-alone duty.

The Grievant

The Grievant had been a CNA for a considerable period before working for the Village. Prior to Baseline 7, R's oxygen administration was "like a work in progress" (Tr. at 90). Third shift was responsible for replenishing R's oxygen prior to R's arising from bed. There were issues prior to Baseline 7. Village managers informed CNAs of complaints, and "we were notified we had issues with the oxygen and that we had to constantly check it" (*Ibid*.). Baseline 7 set a new standard, which the Grievant understood thus: "we would check the oxygen to make sure that it wasn't empty, and if it was empty that we would fill it" (Tr. at 91). The Grievant understood, through his training and experience that filling a portable in the oxygen fill room required his initials for billing purposes. As he understood the process, "we had to sign our initials every time we filled the tank because the resident would be charged for a full fill each time we signed it" (Tr. at 92). As he understood it, this meant a portable should be empty or nearly empty before a fill, to avoid overcharging.

R's care was a team effort. Before and after Baseline 7, employees would watch R, and constantly monitor his oxygen status. The Grievant hooked R to his portable unit after he rose in the morning, and would check R's oxygen throughout the day. His "Y" response on Baseline 7 reflected that he would check R's oxygen throughout the day. His responses reflected that:

> I was under the impression that if it was still flowing, oxygen was still flowing out of the tube that we didn't, we didn't replace that with a full tank. We would let that go to the next shift's responsibility because there was a constant twenty-four hour check and fill thing . . . (Tr. at 96).

The Grievant acknowledged that R's oxygen administration was discussed in report, but was never discussed with him "one on one." He did not fill R's portable on April 17 because he still had "the understanding that if it wasn't empty that we would just check it and not have to fill it" (Tr. at 98). In his view, this was a misunderstanding on his part, which exposed him to discipline. Discipline should highlight what he was doing wrong so that he could address it.

The Grievant has been exposed to oxygen administration throughout his experience as a CNA. He understood that a physician's order does not permit flexibility in interpretation on his part. He was aware R's portable had a capacity of around eight hours, depending on R's level of activity, and this meant that it would probably have to be filled during the day shift.

On April 20, he noted that:

> When I had left I had seen R and his sister coming back into the facility and she was upset, and I realized that she was upset, and I asked my partner, I hope it's not because his oxygen was empty. (Tr. at 106).

He did indicate to MacKenzie, during their April 20 phone conversation, that he hoped to come back to the Village to amend his documentation of Baseline 7. He did indicate to MacKenzie that he hoped to implement a procedure to check R's oxygen late in the shift, and that this was difficult because R was in the workshop at that time of day.

He acknowledged that Knifke and Springstroh testified that they specifically instructed him to fill R's portable at the end of his shift, but stated that he did not come away from their conversations with that understanding. In his view, checking R's portable was an automatic responsibility of the second shift at the start of the shift. Not filling the portable when it was partially full avoided overcharges, and would be checked automatically by the second shift. His view did not abandon R's care, because, "I would hope that the other CNAs and the staff responsible would also be following up through the checks throughout the day because it was all staff responsibility" (Tr. at 111).

Cora Bell

Bell has served the Village as a CNA for roughly thirteen years. Because she regularly worked on palliative care and was seldom involved in oxygen administration, she sought informal refresher training on oxygen administration from nurses and CNAs who were more familiar with it. They walked her through the procedures used in the oxygen fill room, and she understood normal procedure to be that a portable should not be filled until nearly empty to avoid overcharges. She questioned Knifke on whether a CNA could sign a baseline if the CNA had made their best effort to comply. She understood Knifke's response to be that was acceptable. Her question did not concern oxygen administration or a physician's order on a critical health matter.

THE PARTIES' POSITIONS

The Employer's Brief

After a review of the evidence, the County contends that it "had just cause to terminate the Grievant for repeatedly jeopardizing the health of a Brewster Village resident when he falsified medical records and by being untruthful during the investigation of this matter." The County asserts the "basic elements of just cause" are stated in ENTERPRISE WIRE CO., 46 LA 359, 362-365 (DAUGHERTY, 1966). In this case, three of its seven elements are not disputed.

Specific notice of a work rule is necessary as one of these elements, although "dishonesty and falsification of records" are so fundamental "that specific notice is generally not required." The Employer does, however, maintain rules on each of these points and the rules cite "suspension and discharge as the level of discipline to be expected for a first offense." Even if doubt could exist on this point, "the Grievant admitted that he knew that providing oxygen per a medical order is important."

The evidence demonstrates that the County enforces its rules evenhandedly. The County's workforce is competent, which makes situations like that posed here unique. However, the County has terminated an employee where "the employee signed off that (she) had performed a necessary medical procedure, when in fact she did not." The County discharged the employee and the Union did not grieve the matter. The Grievant's "situation is even more severe". In March of 2009, the Grievant was disciplined for falsifying records and for being dishonest in an investigation. The parties entered a settlement agreement "so that the suspension would not serve in the future for progressive discipline", but there is no doubt he was put on notice of the severity of this type of misconduct. The conduct that led to the discharge is even more severe than that of 2009, since he "falsely signed off on a required medical procedure to the medical detriment of a resident."

Since the County appropriately weighed the seriousness of this misconduct against his service record, the evidence meets the Daugherty standards. The Grievant's falsification of records put the resident at risk and "exposed the County to significant liability and potentially jeopardized Brewster Village's status as a licensed facility." His lack of candor and honesty in the investigation is mirrored by his testimony. Detailed review of his testimony establishes that he "was not truthful during the investigation of this case and (he) . . . was not truthful under oath at hearing." Arbitral precedent underscores that dishonesty of this severity is a fundamental break in the trust underlying the employment relationship.

Viewing the record in light of those Daugherty standards that are in dispute, the County concludes that, "Based on the seriousness of the matter and coupled with the fact that the Grievant had been disciplined in the past for falsifying records, termination is the appropriate discipline and this grievance should be denied."

The Union's Brief

After a review of the evidence, the Union contends that just cause demands that the County "first establish conduct by the Grievant in which it has a disciplinary interest." The County must then "establish that the discipline imposed reasonably reflects that interest." Here, the "Grievant acknowledges that he made a mistake, and the Union acknowledges that the County has a disciplinary interest in correcting that mistake." The evidence establishes that the Grievant has consistently maintained that "the decision to check and not necessarily fill the tank was based on his mistaken belief of what the baseline required." Contrary to the County, the Grievant understood Baseline 7 to require him to check the portable and to fill it only if empty. Review of Baseline 7 documentation establishes that "neither the Grievant nor Sue Ryberg . . . executed the baseline properly for the time it was instituted to the time the Grievant was terminated." Referencing the Oxygen Log with Baseline 7 charting "shows that on only one occasion . . . did the employee who indicated on the baseline that they 'checked and filled' the tank actually fill the oxygen tank." Beyond this, Baseline 7 shows that employees initialed it prior to 2:00 p.m., which does not meet the County's view of compliance with Baseline 7. That the resident's sister estimated that the portable was only filled on one or two occasions within the month prior to April 20 further underscores that a significant number of employees did not understand that Baseline 7 meant "always fill".

The Grievant's interpretation of "check and fill" was reasonable, if mistaken. Bell's testimony confirms the Grievant's, thus establishing that prior training taught employees to avoid filling portables until they were nearly empty. This avoided charges for a "full 'fill'" without regard to "whether the tank was one quarter, one half, or three quarters full when re-filled." The Grievant's claims that he was confused regarding the fill procedure "were, and continue to be dismissed far too easily by the County."

The Grievant testified that he constantly checked the portable, and acknowledged that "he initialed the baseline on days where he last checked the tank outside of the 2 pm – 2:30 pm window." County assertion that Baseline 7 is "an on-the-record accounting of the medical services performed by that employee" flies in the face of its "clear acceptance of discrepancies between the baseline and the oxygen log, which indicates who actually filled the oxygen tank." Springstroh even encouraged the Grievant "to allow a co-worker to fill the oxygen tank, despite the fact that (the Grievant) would be initialing the baseline indicating that he had performed the task at a specific time." With this background, the Grievant's conduct cannot be called a falsification of records. At most, the conduct is that he "failed to properly perform certain tasks that were assigned to him." This interest cannot be equated with "dishonesty", which is the asserted basis for the discharge, and which "is totally lacking in merit."

The proven level of misconduct will not reasonably support discharge under the labor agreement or "the general theory of progressive discipline." Section 28.01 states that "the purpose of the disciplinary procedure is to inform employees of what they are doing wrong, and to correct the behavior". This makes discharge appropriate only for egregious or

non-correctable behavior. A warning to the Grievant "would have corrected his behavior." The County never clearly informed the Grievant of its expectation regarding Baseline 7 and never addressed his confusion on the point.

Section 28.02 states the generally applicable progression for discipline and the effective life of warnings. Only one valid warning exists for the Grievant as of the incident at issue here. Under the labor agreement, the next disciplinary step should have been suspension. Section 28.05 clarifies that suspensions may range between two and thirty days. The County improperly failed to exercise its disciplinary interest within this "wide latitude in addressing offenses of varying severity."

Section 28.03 defines the types of egregious misconduct that can warrant immediate discharge. None of the behaviors defined to warrant summary discharge apply here, and "gross negligence" or "willful dereliction of duty" warrant no more than a suspension. The evidence "contains nothing that would suggest that the Grievant intentionally or willfully did anything wrong or harmful." At most, the evidence shows the Grievant's "failure to check the portable oxygen tank between 2 and 2:30 may amount to a failure to exercise reasonable care". The evidence more reliably shows County escalation from a written warning in 2008 to a termination for falsifying records in 2010. This is not supported by Section 28.03 and is inconsistent with County treatment of Michelle Funk.

In sum, the County "has not met its burden of establishing that it had just cause to terminate the Grievant." At most, the proven level of misconduct supports the imposition of a much lower level of discipline. It follows that the grievance should be sustained; the Grievant should be reinstated; and the Grievant should be made whole.

The Employer's Reply Brief

The Union mischaracterizes the record by asserting the Grievant was confused about Baseline 7 or that it was "a work in progress." This ignores that "on a number of days (the Grievant) neither checked nor filled the resident's oxygen tank." It ignores he "falsely signed off on the baseline on days the resident was not at the facility". It ignores he admitted there were days he "neither checked nor filled the tank." Beyond this, it ignores his lack of candor during the investigation and hearing.

There is no reliable evidence that other employees misunderstood Baseline 7. Bell's testimony offers no support for the Grievant, since she neither worked with R nor Baseline 7. That the facility avoids filling certain portables until they are nearly empty for billing purposes has no bearing on this case, in which "a specific baseline was put in place requiring the tank be filled." The Grievant and all other employees knew the portable would last only eight hours. Springstroh's notes do not support the Grievant's testimony, and highlight that she specifically told him to fill the portable on April 17 and 18. Nor will the evidence support the assertion that Ryberg's work performance tracks the Grievant's. In sum, "the Union's explanation of the Grievant's conduct does not square with the record in this case."

Nor do Village records imply that "the central oxygen fill tank log" has any bearing on Baseline 7. Rather, Baseline 7 reflects "a medically required procedure", while the oxygen log is initialed solely for administrative purposes to indicate oxygen has been removed from the oxygen fill room. It has no bearing on Baseline 7, which requires specific notation to establish compliance with a medical procedure. The Grievant's failure to comply with Baseline 7, his falsifying compliance records and his dishonesty when confronted are the key points regarding the discipline.

The Union has no factual support for the assertion that the Grievant's conduct was less than serious, or that it was amenable to lower level discipline. The labor agreement "clearly allows for termination without progressive discipline." The proven misconduct constitutes repeated acts of gross negligence and willful dereliction of duty. Nor will the record support the assertion that the County "treated the Grievant less favorably than other similarly situated employees." That assertion is the Union's burden, and the evidence establishes the Union failed to meet it. The Union's assertion that Funk was more favorably treated than the Grievant ignores that she did not fail to meet "a medical procedure ordered by a doctor." The evidence shows that her conduct did not threaten "serious health consequences or death for the resident." Her situation was not preceded by "several prior reminders" and "did not involve an employee who had previously been disciplined" and was well aware "that falsifying records was serious and could lead to termination." The evidence establishes the County treated her misconduct consistently with its treatment of the Grievant's "first instance regarding records."

The County concludes that the record dictates that "this grievance should be denied."

The Union's Reply Brief

County arguments fall short of establishing conduct that reasonably supports discharge. They ignore specific agreement provisions that establish a progression of discipline that the County failed to follow. Section 28.02 establishes that the next progressive step for the Grievant was suspension, not termination. Section 28.03 does illustrate when progressive steps may be skipped, but none of the proven behavior falls in the egregious types of misconduct addressed by it. Section 28.05 clarifies that a wide range of suspensions were available to the County. The record will not support County failure to exercise the type of discretion granted by Section 28.05.

The record fails to support County allegations that the Grievant acted dishonestly. To the contrary, the evidence establishes that the "Grievant has been consistently honest and cooperative with the employer throughout an investigation where the County seems content playing a game of 'gotcha'." For example, a detailed review of the testimony fails to show that the Grievant was aware that the portable ever ran out of oxygen. Similarly, the evidence shows the County has attempted to portray the Grievant's acknowledged failure to check the portable between 2:00 and 2:30 p.m. as an acknowledgment that he never checked the portable at all. Similarly, the Grievant's admission that he did not follow Baseline 7 regarding the specific time to check the portable cannot be made into an admission that he never checked it.

The County mischaracterizes the settlement agreement by including "them in the record under the guise of an argument regarding 'notice'." The underlying notices are invalid for progressive discipline purposes. Mackenzie's testimony establishes that they were considered for purposes of determining discipline. The settlement agreement makes this improper.

In sum, the "County has failed to demonstrate that the actions of the Grievant justify a departure from the sequence of discipline as specifically defined by the plain language of the Collective Bargaining Agreement." Specifically, the County has failed to establish dishonesty. It follows that the grievance should be sustained; the Grievant should be reinstated; and the Grievant should be made whole.

DISCUSSION

I have not selected either party's statement of the issues. Explanation of this point prefaces review of the record. The County's view, coupled with its citation of Section 1.02, point toward work rules. I am not convinced work rules assist in the grievance's resolution, since Articles I and XXVIII comprehensively address progressive discipline and standards governing discharge. The Union's view does not pose the potential issue of remedy and broadly refers to a violation of the collective bargaining agreement. My statement of the issues makes potential remedial issues express, and focuses the issue on the merits to "proper cause" under Section 1.01.

The Union's view of the issue is appropriate, since the agreement states the discharge standard in several ways. Section 1.01 uses "proper cause"; Section 28.02 uses "just cause"; and Section 28.03 uses "cause". My statement of the issue sets proper cause as the standard. This does mean there is a conflict between the sections. The parties do not assert a conflict and there is no reason to imply one, as underscored by *Management Rights*, Hill & Sinicropi, (BNA, 1986) at 99: "The term 'just cause' is generally held to be synonymous with 'cause,' 'proper cause,' or 'reasonable cause.'"

The County uses the seven Daugherty standards to define proper cause. The Union does not. In the absence of stipulation, I view the proper cause analysis to consist of two elements. The first is that the Employer must establish employee conduct in which it has a disciplinary interest. The second is that the Employer must establish that the discipline imposed reasonably reflects its disciplinary interest. This does not state a non-contractual standard, but a skeletal outline that the parties' arguments flesh out.

In a sense, Union acknowledgement that the Grievant engaged in conduct in which the County has a disciplinary interest makes the first element undisputed. However, the parties closely dispute application of the second element, and it is thus necessary to detail the proven misconduct. Resolution of disputed fact under the first element largely addresses the second.

As the Union asserts, application of the first element is problematic. The allegation that the Grievant falsified records requires a determination of intent. Standing alone, that determination is problematic. Beyond this, R's oxygen administration prior to and following Baseline 7 was a matter of team coverage. R is mobile and is involved in activity throughout the Village, including work shop activities near the end of the Grievant's shift. Those activities do not necessarily put the Grievant and R together. R's mobility spread responsibility for his around the clock oxygen administration across a group of providers and across shifts. Breakdowns in oxygen administration prompted Knifke to write Baseline 7. Apart from the Grievant's charting regarding Baseline 7, there is some reason to question its clarity. "Check and fill" is less precise than "Check operation of tank and then fill" or "Check operation of tank; check tank capacity; fill if less than 75% full".

The strength of the Union's arguments, however, breaks down on review of the evidence and particularly on review of the Grievant's testimony. It is not necessary to find intent to conclude that undisputed charting irregularities establish misconduct. That the Grievant made chart entries on Baseline 7 that do not reflect fact is, standing alone, significant.

This, and other undisputed fact, pose a troublesome backdrop to review of the Grievant's testimony. The Grievant is an experienced CNA who was familiar with oxygen administration. He knew that a significant incident prompted the directive for R's around the clock oxygen administration. He knew that compliance with the directive granted no flexibility regarding its implementation. That implementation of the directive was a group or cross-shift responsibility cannot obscure that the Grievant was R's primary care giver. More to the point, Knifke's and Springstroh's credible testimony establish that he was specifically informed several times of the need to keep R's portable replenished. Whatever is said of the clarity of Baseline 7, it is undisputed that the Grievant is the sole CNA who failed to understand it. Bell's testimony affords no support for the Grievant's "misunderstanding". Even if the two employees were aware that filling a partially full portable risked overcharging, there is no evidence that the Grievant checked R's portable at any time other than March 31 with sufficient diligence to question its capacity to make it through first shift. Bell's testimony that a "best effort" could justify a chart entry stating compliance with a baseline has no bearing on Baseline 7 compliance. Baseline 7 concerns a physician's order on an acute care issue.

The Grievant's testimony is the weakest aspect of the Union's case. He was an articulate witness and an experienced CNA. That he would require one on one instruction to understand Baseline 7 is implausible. In spite of this, his testimony offers no reliable explanation for his conduct. It is unclear why he consistently entered "Y" to chart his compliance with Baseline 7. The assertion that this reflects that he checked R's portable during other parts of the day or that he did so to remind himself to check R's portable between 2:00 and 2:30 p.m. shows no regard for the veracity of a medical record. This is starkly underscored by his checking "Y" on Baseline 7 when R was not in the facility. Beyond this, if the Grievant regularly checked R's portable, it is not evident why his initials appear on the oxygen log only on March 31. That he wished to avoid overcharges, coupled to the assertion he regularly checked R's portable, implies he never found the portable close enough to empty

to refill. If this is the case, it is impossible to understand the ongoing complaints regarding the portable being empty prior to the second shift. It is no easier to understand how second shift employees had to fill the portable early in their shift. Beyond this, his assertion that second shift employees were obligated to automatically check R's portable is without any support. His comparing the transition from third to first shift with the transition from first to second is unfounded. Third shift had to keep the canister full to permit R's access to oxygen while asleep. The Grievant had to hook R to the portable to permit him to leave bed. Checking the portable at that point could be considered "automatic." However, there is no such corresponding event in the transition from first to second shift. His assertion that a group had responsibility for R's care ignores that the Grievant had to check R's portable at the start of his shift; that the Grievant knew the expected life of a full portable was no more than eight hours; and that the Grievant was R's primary care giver. The Grievant's assertion that end-of-shift duties such as garbage removal conflicted with his obligation under Baseline 7 requires no rebuttal. At best, it reflects an improper choice of priorities.

The following passage highlights the difficulty posed by the Grievant's testimony:

Q You knew during the course of the discussions over this issue that he was running out of his oxygen; right?
A That he was getting low on his oxygen, yes.
Q You knew that even in the discussions within the staffing that part of the complaint from his sister was that he was out of his oxygen; right?
A To make sure it was still functioning, yes.
Q Are you suggesting that you didn't know that the sister's complaint was that he was out of oxygen?
A I didn't know that.
Q You never heard that?
A I know that it was mentioned in report that we constantly need to watch his oxygen so he would not run out, yes. I didn't know the details of the whole reasoning. I know his sister had complained his oxygen would be low or not there so – (Tr. at 112-113)

No evidence in the record supports the assertion any of R's caregivers did not know that R's sister had complained to Village managers that R's portable ran out of oxygen during their visits. The quoted passage on this point reflects a broader one. Standing alone, his testimony offers less a consistent explanation of his conduct than a disjointed response to challenges.

His testimony does not stand alone, and the credibility of Village witnesses poses a harsh contrast. MacKenzie's documentation and testimony highlight that the Grievant's responses reflect less a coherent account of how he behaved than a fluid attempt to address questions concerning his behavior. From the April 20 phone call, the Grievant consistently failed to answer the Employer's concerns. Knifke's and Springstroh's testimony establish a detailed attempt to clarify the need to fill R's portable before the end of first shift. The

Grievant's acknowledgement of the conversations cannot be reconciled to his failure to check R's portable. Two specific counseling efforts preceded the problems of April 20. Ongoing problems from April 17 through April 20 are inexplicable.

In sum, the Employer has demonstrated that the Grievant failed to honestly chart his compliance with Baseline 7. The Employer has further demonstrated that the Grievant failed to candidly account for his behavior during the investigation, and that he failed to candidly account for his behavior during the arbitration hearing.

This turns the analysis to the second element of the proper cause analysis. As the Union points out, the labor agreement offers considerable guidance regarding the application of this element. Section 28.01 establishes that discipline should not be punitive. Section 28.02 establishes the normal progression of discipline. Section 28.05 establishes considerable latitude in the imposition of suspension, which is, under Section 28.02, the step that normally precedes discharge. Section 28.03 establishes that "gross negligence or willful dereliction of duty" is "immediate cause for suspension".

Significantly, Section 28.03 makes immediate discharge an act of discretion. The first sentence establishes that the normal sequence of progressive discipline "shall not apply in cases which are cause for immediate suspension or discharge." The Union asserts that the second sentence of the section, read with Sections 28.01 and 28.05, grant a preference for using suspension rather than discharge. The second sentence of Section 28.03 underscores that immediate discharge demands conduct no less severe than gross negligence or willful dereliction of duty. This does not, however, mandate suspension rather than discharge for that type of misconduct. Rather, the second sentence establishes that the listed behaviors require no discipline prior to suspension. The first sentence authorizes the County to exercise discretion over whether to suspend or discharge for egregious misconduct. To conclude otherwise introduces an unnecessary conflict between the first and second sentences.

This interpretive nicety is not necessarily posed on these facts, because the proven lack of candor goes beyond a "willful dereliction of duty." The County has established that MacKenzie reasonably concluded that he could not trust the Grievant's charting or his explanation of his charting. As the County asserts, this is a fundamental breach of the employment relationship warranting departure from progressive discipline. R's vulnerability highlights the significance of this breach. The weakness of the Grievant's testimony undermines the strength of the Union's contractual position regarding County use of progressive discipline.

The basis for this conclusion is best explained by tying it to the parties' arguments. The Union's argument that the County failed to prove the Grievant falsified medical records has force. As noted above, the weakness of the County's position is the difficulty of proving intent. "Proper cause" is ultimately a reasonableness review of the Employer's exercise of discretion. I do not believe it is necessary to divine the Grievant's intent. Work behavior is a more reliable guide, and is ultimately the object of discipline and the source of an employee's

defense to discipline. More to the point, the weakness in the Union's position is that the Grievant's account, at hearing and in the investigation, shows a fundamental disregard for the accuracy of charting information, and for accepting responsibility for his actions. His response to ongoing counseling efforts on the point belies his experience and the intelligence he displayed as a witness. Whether this constitutes dishonesty as an ethical matter is a more subtle point than an arbitrator can reach. More to the point, his lack of candor is proven and MacKenzie had a reasonable basis in fact to infer dishonesty. More to point regarding the second element of proper cause, MacKenzie reasonably concluded that the misconduct was so fundamental and continuous a breach in the employment relationship that the behavior was not amenable to progressive discipline.

This acknowledges the persuasive force of the Union's position regarding the impact of the January settlement agreement on the interpretation of Article XXVIII. If the evidence supported the Union's argument that the Grievant was cooperative and candid throughout the process, its assertion that discipline short of discharge is contractually required would be persuasive. The difficulty is that the asserted candor and cooperation is unproven. The proven misconduct is more than a rare deficient, but good faith, failure to comply with Baseline 7. Rather, the proven misconduct involves not just the failure to comply with Baseline 7 regarding R's oxygen administration, but ongoing dishonesty in charting. The misconduct was not rare, but spanned a considerable period of time on an acute care issue, and continued in spite of specific counseling on how to comply.

Union assertion that MacKenzie's consideration of the Grievant's entire personnel file violated the grievance settlement agreement and Section 28.02 is well founded. The weakness in the assertion is that it presumes the "general rule" of "the sequence of disciplinary action" under Section 28.02 governs the grievance. The evidence demonstrates that the grievance turns on the first sentence of Section 28.03, and specifically on whether the proven misconduct constitutes "cause" for "immediate . . . discharge." Under that provision, MacKenzie did not review the April, 2009 suspension to determine the level of progressive discipline. Rather, he viewed the Grievant's entire personnel file to determine if the Grievant's conduct during R's oxygen administration warranted immediate discharge. In the same way a record of solid work performance can advocate for viewing a specific act of misconduct as an aberration amenable to progressive discipline, a record of less than honest conduct can advocate for viewing a specific act of misconduct as egregious and not amenable to progressive discipline. This act of discretion is authorized by the first sentence of Section 28.03. If the evidence established the level of misconduct asserted by the Union, then its assertion of Section 28.02 as the governing provision would be persuasive, and MacKenzie's consideration of the April, 2009 suspension would violate the settlement agreement.

Evidence of discipline regarding other employees is not determinative here. The County discharged an LPN for charting that she completed a medical treatment that she did not, in fact, complete. This generally highlights the significance of charting, but affords no specific guidance regarding the grievance. The Union asserts that a suspension received by Michelle Funk in June for "falsification of records" indicates disparate treatment regarding the

Grievant's discharge for the same offense. As with the LPN discharge, the evidence affords general guidance only, since falsification of records can provoke progressive discipline under Section 28.02 or immediate discharge under Section 28.03. To have specific applicability here, the evidence would have to be more detailed. Funk's June suspension did not involve an acute care issue and there is no reliable indication that her conduct involved dishonesty. MacKenzie did not discipline Ryberg. Her initials do not appear on the oxygen log and she consistently entered a "Y" response regarding compliance with Baseline 7. She did not, however, sign off on Baseline 7 when she knew R was not in the facility. The Grievant did. Nor did MacKenzie's investigation link Ryberg to a complaint that R's portable became empty while she was his primary care giver. The Union asserts Ryberg may have failed to check the portable, but the evidence permits no reliable conclusion. It may indicate she checked the portable and found that other employees had filled it. Whether she was conscientious or fortunate, her situation is not comparable to the Grievant's. His charting was improper; his account of his charting was unreliable; and in spite of specific counseling he failed to fill R's portable on numerous occasions in which it should have been filled to comply with Baseline 7.

Against this background, the County has met both elements of the proper cause standard.

AWARD

The Employer did have proper cause to discharge the Grievant.

The grievance is, therefore, denied.

Dated at Madison, Wisconsin, this 4th day of April, 2011.

Richard B. McLaughlin /s/
Richard B. McLaughlin, Arbitrator

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