BEFORE THE ARBITRATOR

In the Matter of an Arbitration of a Dispute Between

KENOSHA COUNTY INSTITUTIONS EMPLOYEES LOCAL 1392 AFSCME, AFL-CIO

and

KENOSHA COUNTY

Case 294
No. 70133
MA-14875

(Anderson grievance)

Appearances:

Nick Kasmer, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, P.O. Box 580734, Pleasant Prairie, Wisconsin 53158, appearing on behalf of the labor organization.

Lorette Mitchell, Senior Assistant Corporation Counsel, Kenosha County, Kenosha County Courthouse, 912 - 56th Street, Kenosha, Wisconsin 53140, appearing on behalf of the municipal employer.

ARBITRATION AWARD

Kenosha County Institutions Employees Local 1392, AFSCME, AFL-CIO and Kenosha County are parties to a collective bargaining agreement which provides for final and binding arbitration of disputes arising there under. On August 30, 2010, the union made a request, in which the county concurred, for the Wisconsin Employment Relations Commission to provide a panel of seven commissioners and staff members from which they could choose an arbitrator to hear and decide a grievance concerning the application and interpretation of the terms of the agreement relating to discipline. The commission did so on September 2, 2010. On September 28, 2010, the parties notified the commission they had selected Stuart D. Levitan to serve as the impartial arbitrator. Hearing in the matter was held in Kenosha, Wisconsin on December 16, 2010. The parties filed written arguments by March 11, 2011, and on March 16, 2011 waived their right to file replies.

ISSUE

Did the County violate the collective bargaining agreement when it terminated Certified Nursing Assistant Lori Anderson in March, 2010? If so, what is the appropriate remedy?

RELEVANT CONTRACTUAL PROVISIONS

ARTICLE I – RECOGNITION

Section 1.2 Management Rights. Except as otherwise provided in this Agreement, the County retains all the normal rights and functions of management and those that it has by law. Without limiting the generality of the foregoing, this includes the right to … demote or suspend or otherwise discharge or discipline for proper cause; …..

. . .

ARTICLE III – GRIEVANCE PROCEDURE

Section 3.5. Work Rules and Discipline. Employees shall comply with all provisions of this Agreement and all reasonable work rules. Employees may be disciplined for violation thereof under the terms of this Agreement, but only for just cause and in a fair and impartial manner. Excluding discipline for patient abuse, any employee who has not been disciplined for any reason for a period of three (3) years shall be considered as having a clean record as of the end of such three (3) year period. When any employee is being disciplined for discharged, there shall be a Union representative present and a copy of the reprimand sent to the Union and the employee.

The foregoing procedure shall govern any claim by an employee that he has been disciplined or discharged without just cause. Should any action on the part of the County become the subject of arbitration, such described action may be affirmed, revoked, modified in any manner not inconsistent with the terms of this Agreement.

. . .

Section 3.8. Suspension and Discharge. No employee shall be subject to discharge without first sustaining a suspension from work for a period of at least three (3) days. During the suspension period, the County and Union representatives shall investigate and review the circumstances involved and then meet and attempt to resolve the issue. If not resolved and the employee is discharged, the grievance must be filed within five (5) workdays of the

notification of discharge and shall be processed beginning at Step 3 of the grievance procedure.

OTHER RELEVANT PROVISIONS

KENOSHA COUNTY DISCIPLINE POLICY REPORT #139

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Purpose

The intent of this discipline policy is to ensure that unacceptable conduct and performance issues are addressed promptly and appropriately. It provides employees with notice when performance standards are not met or when standards of conduct are violated. This discipline policy also advises the employee of the action needed to improve the deficiency and a time table for improvement. Discipline shall be respectful and equitable and discipline measures shall all be appropriate to the infraction.

This policy, which applies to all Kenosha County employees, has two main purposes:

- To set guidelines of what the County considers to be minor and major behavior and performance deviations from the work rules, and
- To establish procedures for dealing with inappropriate behavior and performance issues.

This policy is based on the premise that when expectations are clear, misunderstandings are few. Recognizing the behaviors that will result in disciplinary action enables us to work together to maintain the standards that make us a high performance organization.

Policy

The art of discipline is intended to be positive in nature and attempts to correct unacceptable employee actions. This attempt may include counseling sessions, personal improvement plans, and other help with the purpose of improving the behavior or an employee that may be detrimental and disruptive to the effective operations of a department, division and/or work program.

In the process of trying to assist the employee to resolve problems and improve his/her behavior, corrective action may be necessary. This corrective action may include discipline.

Progressive discipline is basically a series of disciplinary actions, corrective in nature, starting with a verbal or written reprimand. Each time the same or similar infractions occur, more stringent disciplinary action takes place. It is important when invoking progressive discipline, that each time disciplinary action is contemplated, it must be definitely established that an infraction did occur which is organizationally inappropriate. To definitely establish that an infraction did occur means that a supervisor must be able to sufficiently substantiate the occurrence of any infraction.

After the infraction has been established, then an assessment of the type of corrective action required is made, taking into account the previous disciplinary actions that have been taken, if any. It does not necessarily mean that an employee is required to violate the same rule or have the same incident occur in order to draw upon previous corrective disciplinary actions.

If there is a general pattern in the employee's behavior previous disciplinary actions can be used in determining the next level of progressive discipline. When there is a series of minor infractions and where there have been several verbal reprimands, written reprimands or suspensions occurring over a period of time the previous disciplinary actions can be included and used in determining the next level of progressive discipline. If past behavior relates to the present problem, past actions should be taken into consideration.

Where the County believes there has been a serious offense, suspension and/or termination may be the first and only disciplinary step taken. Any step of the disciplinary process may be skipped at the discretion of Kenosha County after investigation and analysis of the total situation, past practice, employee's record and circumstances.

Upon taking any disciplinary action, with the exception of discharge, the employee must be notified at that time that any continued involvement in that particular negative behavior will result in progressive disciplinary action up to and including discharge. The various levels of discipline are: verbal reprimand, written reprimand, suspension, demotion, and discharge.

. . .

Levels of Disciplinary Action

Verbal Reprimand

A verbal reprimand defines an inappropriate action or omission which includes a warning that the incident is not to be repeated. A verbal reprimand, when required, shall be given orally by the employee's immediate supervisor. The

reprimand should be given in a private meeting. Verbal reprimands must be documented for the personnel file in order to substantiate the start of progressive discipline. The documentation should be recorded on the disciplinary form. The employee must be told clearly, as is required at other disciplinary levels, what the infraction is, how to correct the problem and explicitly inform the employee what further disciplinary action may result for failure to comply with recommended corrective action.

Verbal reprimands will remain valid for six (6) months. Examples of first offense verbal reprimands (but not limited to those listed) are:

- First last arrival (tardy) for scheduled shift
- First time extending the length of your break or lunch period
- Isolated mistake with minor consequences or a job duty done incorrectly
- Failure to complete and submit accident and sickness benefit forms on time

Written Reprimand

A written reprimand may follow one or more verbal reprimands issued to an employee for a repeated offense. A verbal reprimand need not precede a written reprimand. A written reprimand should be used for repetition of an offense that originally caused a verbal reprimand. Infractions of a more serious nature may be discipline(d) initially for (sic) a written reprimand. The written reprimand shall be issued to the employee by the immediate supervisor in a private meeting. The immediate supervisor shall inform the employee of any past verbal reprimands issued to the employee for similar infractions. The supervisor shall explain the reasons for the issuance of the written reprimand; again, suggestions for correcting the behavior are issued together with a warning of what discipline, up to an including dismissal may be taken in the future if behavior or performance does not improve.

Written reprimands will remain valid for one year. Examples of first offense written reprimands (but not limited to those listed) are:

- Inappropriate or rude interactions with a member of the public such as a raised voice, sarcastic comments, or impatience
- Failure to show up for a scheduled shift
- Insubordination such as talking back to a member of management
- Lack of adherence to performance standards
- Repeatedly failing to complete and submit accident and sickness benefit forms on time.

Suspension

A suspension is a temporary removal of the employee from the payroll. A suspension may be recommended when lesser forms of disciplinary action have not corrected the employee's behavior. Suspensions may also be recommended for first offenses of a more serious nature. A suspension will remain valid for an employee's entire length of employment.

Suspensions may be imposed on an employee for repeated offenses when verbal reprimands and written reprimands have not brought about corrected behavior, or for first offenses of a more serious nature. Examples of some of the more serious infractions (but not limited to those listed) are:

- Major deviations from work rules, including a violation of safety rules
- Having any measurable level of alcohol while on the job
- Falsification or misuse of time sheets or records
- Fighting
- Excessive absenteeism
- Theft or any form of dishonesty
- Harassment
- An incident of verbal abuse to a member of the public, co-worker, management or an individual in the County's care, custody or control.

The number of days recommended for suspension will depend on the severity of the act. Commission of the above offenses may also result in a recommendation for discharge.

Discharge

Discharge may be recommended for an employee when other disciplinary steps have failed to correct improper action by an employee, or for first offenses of a serious nature. Examples of some of the more serious infractions (but not limited to those listed) are:

- Having any measureable level of alcohol or drugs while on the job
- Possession of an unauthorized weapon or fire arm while on the premises
- Insubordination
- Physical or sexual assault
- Theft of County property or funds

- Sleeping while on duty
- Off duty misconduct
- Sexual harassment or discrimination
- Acts of fraud or dishonesty
- Consistently failing to meet performance expectations
- Isolated mistake with major consequences or potential liability

KENOSHA COUNTY WORK RULES

Work Habits 1 Employees shall be courteous and polite at all times while on duty or while engaged in work-related situations.

Deportment 2 Discourteous or disrespectful treatment of others or the use of profanity or threatening language.

Deportment 3 Physical or verbal abuse or intimidation of any individual, including those under the County's care, control or custody.

WISCONSIN ADMINISTRATIVE CODE
DHS 13 – REPORTING AND INVESTIGATION OF CAREGIVER MISCONDUCT

DHS 13.03 Definitions. In this chapter:

(1) (a) "Abuse" means any of the following:

1. An act or repeated acts by a caregiver or nonclient resident, including but not limited to restraint, isolation or confinement that, when contrary to the entity's policies and procedures, not a part of the client's treatment plan and done intentionally to cause harm, does any of the following:

   a. Causes or could reasonably be expected to cause pain or injury to a client or the death of a client, and the act does not constitute self-defense as defined in s. 939.48, Stats.

   b. Substantially disregards a client's rights under ch. 50 or 51, Stats., or a caregiver's duties and obligations to a client.

   c. Causes or could reasonable be expected to cause mental or emotional damage to a client, including harm to the client's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression,

outward aggressive behavior, agitation, or a fear of harm or death, or a combination of these behaviors. This subdivision does not apply to permissible restraint, isolation, or confinement implemented by order of a court or as permitted by statute.

(b) Abuse" does not include an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance as the result of inability, incapacity, inadvertency, or ordinary negligence in isolated instances, or good faith errors in judgment or discretion.

CODE OF FEDERAL REGULATIONS

Title 42: Public Health
Part 488 – Survey, Certification, and Enforcement Procedures
Subpart E – Survey and Certification of Long-Term Care Facilities
CFR 488.301 Definitions

. . .

Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

. . .

BACKGROUND

Brookside Care Center (BCC) is a 154-bed skilled nursing facility owned and operated by Kenosha County, staffed by about 100 certified nursing assistants (CNA's) and about 50 registered nurses. This grievance concerns the March, 2010 termination of one of its CNA's, Lori Anderson, for allegedly verbally abusing and intimidating a 93-year-old resident, Elizabeth O. (EO), who had been admitted in January, 2010 after she broke her hip. [1]

Anderson, who has a loud and somewhat brassy voice, began working at BCC on April 19, 1996. Her performance rating at her three-month review was mediocre; on a five-point grid, she received six ratings of 2 (needs improvement) and one rating of 3 (good). Her final probationary evaluation in September, 1996 was significantly better, with five ratings of 4 (very good) and two ratings of 5 (outstanding). Her supervisor added the following comment:

[1] The Diagnoses on EO's Plan of Care read as follows: "Aftercare for healing traumatic fracture of hip – REHABILITATION PRO NEC – ATRIAL FIBRILLATION – RHEUMATOID ARTHRITIS – POSTINFLAM PUL FIBROSIS
Personal history of certain other diseases, venous thrombosis and embolism – Bronchiectasis, bronchiectasis without acute exacerbation – HYPERTENSION NOS

> Has been noted to have improved a lot on her skills and time management. Always very pleasant (with) others. Needs to look (at) care cards when trying to work on a line up. Still needs to be reminded of resident schedule like staffings etc.

On Anderson's first annual evaluation, she received five ratings of 3 and two ratings of 4, with the following commentary: "It appears Lori is more comfortable in her CNA position at BCC. Has improved and contributed to the team approach. Quiet but kind to the residents." In 1999, Anderson scored 42 points out of a possible 60, for an overall rating of "very good," with the following commentary: "I believe this past year Lori has become more comfortable and self confident in her position at BCC, and it shows in her care for the residents." In 2000, she scored 33 points, for an overall rating of "good," with the commentary that she "must improve her inservice attendance." From 2001 to 2004, Anderson scored between 42 and 46 points, ending each year with a rating of "very good." Among the comments in those years, "Gets along well with others," "takes great pride in her work," "residents always neat + well groomed," and "self directing." The only negative comments were regarding tardiness, attendance, and meeting in-service requirements. For 2008 and 2009, BCC changed to a 15-item grid, with Anderson scoring a total of 53 and 51 points, equivalent to a "very good" and "good" rating, respectively. Among the comments, "difficulty relating to some peers but has made steps toward improve(ment)," "great with new residents," "Employee has improved with monitoring her 'tone' when speaking so not to be misunderstood by others. Thank you!," "always completes tasks in a timely manner," and "patients are given individualized care."

In March, 2010, Anderson was assigned to the hall in which EO lived, but EO was not one of her assigned residents. For a period of about thirty minutes, as shifts were changing, Anderson was the only CNA working on that hall. On March 9, Anderson responded to EO's call light. The encounter that ensued led to EO's daughters filing a complaint with BCC, which BCC summarized as follows: [2]

> Elizabeth O's daughters verbalized that they felt a CNA was "crabby" and treated their mother like a 5 year old. They said that the CNA told the patient to be more patient and have more "compassion" for the CNA. They said the CNA scolded the patient for telling her that she had to go to the bathroom after she put the legs on the w(heel)/c(hair). They said the CNA told the patient about going to assisted living facility if the patient went the patients usually die in their sleep or have a heart attack. The patient said she's afraid to push call button. [3]

Following the complaint by EO's daughters, BCC began an investigation, which included taking statements from EO and her daughters. Jamie Fesko, RN, who supervised

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[2] Each witness statement bore a slightly different, but essentially identical, introductory statement handwritten by BCC nursing supervisor Jamie Fesko.

[3] As noted below, only one daughter, Christine Parker, said she heard Anderson make the comment to EO about dying in an assisted living facility. The assertion in this statement that "*they* said the CNA told the patient…" is thus not accurate.

Anderson and other staff on the second shift, conducted the interviews. Fesko filed a narrative as the "statement taken for patient," as follows:

> Elizabeth said that she asked the CNA, Lori Anderson, to help her to the w(heel)/c(hair). After Lori helped Elizabeth to the w/c Elizabeth realized she had to use the bathroom. When she told Lori she said that Lori told her (she) should have known better. Elizabeth said this made her feel "belittled, foolish and as if she was asking for too much." She said that frequently Lori makes her feel "guilty for asking for help, as if she should be apologizing for requesting help, and often humiliated." Elizabeth said she's afraid to call for help for fear of "angering Lori" if she's the one to answer her light and because she doesn't want to be "scolded." Elizabeth said that she didn't want to "upset Lori" by complaining & verbalized fears of backlash. Elizabeth said that Lori told her she "had no compassion" for Lori & that Elizabeth was "one of many patients." Elizabeth said she feels "rushed" by Lori and this makes her "uncomfortable." Elizabeth said that in her opinion Lori "doesn't treat patients right," "is cranky", "harsh", and "bossy." Elizabeth said that Lori "pushes her to do more for herself then (sic) she feels 'safe' doing" but she tries to perform these tasks to keep Lori from berating her for "not trying." [4]

Fesko testified that EO was "lucid," and "able to explain the incident in detail, step by step." Fesko testified she was "pretty sure" EO's daughters were in the room when Fesko took the statement. Fesko testified that "no concerns" about Anderson had been made known to her prior to this incident.

EO's daughters each submitted a written statement. Daughter Christine Parker's statement read as follows:

> My mother asked to get out of bed and Lori came in and put her in the wheelchair and added stirrups. My mother said she needed to use the bathroom and was scolded and was told she should of said something sooner as the stirrups where not the easiest thing to do and she was busy. When in the bathroom she insisted my mother help herself by getting her underwear & pants down herself by holding on to a bar. My mom then asked to have her socks instead of her shoes and was told she should be doing this herself. After Lori put one sock on she made my mother try to put the other one on which was the leg with the broken hip. My mom couldn't even reach her foot or lift her leg. My mom then proceeded to make conversation telling her that her daughters were looking into getting her into assisted living and then was told she would probably only be there for approx. 3 mo and would have a heart attack or die in her sleep or would end up back at Brookside.

[4] Fesko explained that EO did not sign the form because she suffers from rheumatoid arthritis.

Daughter Petty Ceilesh's statement read as follows:

> My mother, Elizabeth O(*****), has on several occasions expressed her concerns about one aide who has been in charge of her care. She said the woman is usually crabby and stern when helping my mother. She (mom) said everyone else has been very nice. One day, my mom said the aide told her that she had "no compassion" as she had a hard job and many people to take care of and my mother was just one of many. Mom said she dreaded using her call button for fear this aide would show up to help her.

Anderson wrote the following response:

> I answered her light. Res. was sitting on edge of bed. Daughter in chair by the door. Res wanted to get into wh(eel)ch(air) so I greeted both of them asked what was needed. So I put Res. in chair + leg pedals on. We were talking about her maybe going to assisted living. I shouldn't have but did say that you have to be able to take care of yourself to a certain degree and you are at Brookside already. Then resident says she wants to use bathroom. "Oh, I wish you would have said that before I put the pedals on. They aren't the easiest things to work with.(") Brought her into bathroom + asked her to stand which she did then asked her if she could pull down her pants which she did and she was capable of turning + sitting down. I helped her with the wiping and getting back in chair. (Res wanted non slip socks and I brought them to her and put the left one on and asked her if she could put the right one on. Two small attempts – no success so I put them on for her.) This was prior to the bathroom. There was no mention of a heart attack in 3 months. That sounds like terrorist talk. And I wouldn't say anything like that. I don't believe I treated her like a five yr. old. I want the resident to be as independent as possible. I love my job. And I work very hard to keep my residents happy. I am more than willing to apologize for any offense. I will (illegible) a softer (illegible)….

On March 11, 2010, Brookside Director of Nursing Barbara J. Beardsley, R.N., wrote Anderson the following letter:

> You are hereby advised that on March 15th at 10:30 in the am in the Brookside Care Center conference room; there will be a pre-disciplinary meeting to discuss the charges of unsatisfactory performance. This is the result of an investigation of a patient complaint in which you caused a resident mental distress by "scolding" her and making inappropriate verbal comments to her. The resident also felt intimidated and was afraid to put on her call light for fear that you would answer and "scold" her again. Her daughters also witnessed some of your behavior towards their mother and overheard your comments. They were very upset by these interactions as well. This complaint has been forwarded to the Department of Health Services, Division of Quality Assurance Office of

Caregiver Quality in compliance with State and Federal regulations as a potential case of mental abuse of a resident.

The details of the complaint are as follows: On 3/10/10, Resident E.O.'s daughters approached the A.D.O.N. and asked to file a complaint. They stated that a C.N.A. (identified as you) who was assigned to their mother that day was crabby and treated their mother like a 5 year old. They also stated the C.N.A. came in to get their mother up, transferred her to a wheelchair and applied the stirrups (pedals). Their mother asked to go to the bathroom and the C.N.A. told her she should have asked earlier as the stirrups (pedals) were not the easiest thing to do and that she (C.N.A.) was busy. She stated then the C.N.A. took her mother into the bathroom and insisted that the resident pull her own pants down while holding onto the bar. After that, the resident requested to have her socks put on. The C.N.A. applied one and told the resident that she should be doing this herself. The C.N.A. made the resident try to apply the other sock. The daughter stated this was the leg with the broken hip and that her mother couldn't even reach her foot or lift her leg. Then the resident began making conversation by telling you that her daughters were looking into getting her into assisted living and you told her she would probably only be there for 3 months and would have a "heart attack" or die in her sleep or would end up back at Brookside.

The second daughter present stated that her mother has on several occasions, expressed concerns about one aide who has been in charge of her care. She said the woman is usually crabby and stern when helping her mother. E.O. told her daughter that one day you told her that she has "no compassion" for you and that you have a hard job and many people to take care of and that she was just one of many. The daughters indicated that their mother was afraid to put her call light on as you might be the one to answer and scold her again for asking for help.

When interviewed by the supervisor that evening, the resident confirmed these concerns as voiced by the daughters. She said your behavior made her feel "belittled, foolish, and as if she was asking for too much." She stated you make her feel guilty for asking for help as if she should be apologizing and that she often feels "humiliated." She was also afraid of reporting her concerns as she was fearful of "backlash." The resident stated that you don't treat patient's (sic) right, that you are cranky, bossy and harsh. She states you push her to do more for herself than she feels safe doing, but she does it to keep you from "berating" her for not trying.

I spoke with you on 3/11/10 shortly after receiving this complaint. I told you what the daughters said about your behavior and performance and asked you to complete a statement about telling what happened. When I read you the

statements from the daughters, you acknowledged that that was probably correct. You stated that you probably were crabby and stern, but that you were just trying to encourage the resident to do what she can for herself. When asked what the care plan said about what the resident should be doing for herself, you stated that you don't look at the care plans, you rely on the nurses to tell you what the residents should be doing, but they often don't. You also stated that the part about the assisted living was correct because that is often what happens, people end up back here. You admitted to being inappropriate with the resident. [5]

Your actions are in violation of the Kenosha County Uniform Work Rules, specifically: Work habits 1 and Deportment, 2 and 3.

You have been previously spoken with regarding your tone of voice and demeanor as reflected in past performance evaluations.
Due to the serious nature of this violation and the negative effect it had on the resident and family members, we are considering termination of your employment.

You may have a Union Representative present at this meeting.

You are hereby advised that you have the right to a pre-disciplinary meeting to dispute the charges against you. You may waive your right to this meeting and admit that the charges are true. If you waive your right to the meeting, termination may be imposed without further action or notice.

Please contact me at 262-XXX-XXXX if you have any questions.

Sincerely,
Barbara J. Beardsley, R.N.
Director of Nursing
Brookside Care Center

I hereby waive my right to a pre-disciplinary meeting upon the charges enumerated above, and state that they are true in substance and fact.

Anderson did not sign the above statement waiving her right to a pre-disciplinary meeting, which was held on March 15, 2010. The record does not indicate at what time the 10:30 meeting ended. At 1:06, Petrick sent AFSCME representative Kasmer the following e-mail:

[5] Notwithstanding the penultimate sentence in this paragraph, Beardsley testified at hearing that Anderson denied making the statement about the implications to EO of going to an assisted living facility.

Nick: Here is my decision.

Thanks,

Fran

Attached was a copy of the letter she wrote to Anderson, as follows:

Dear Lori Anderson:

A due cause hearing was held today. You were present as well as union members, Janet Ling, Jennifer Burroughs and AFSCME representative, Nick Kasmer. Management representatives were Bob Riedl, Personnel Director and Barbara Beardsley DON.

Ms. Beardsley presented management's case which detailed statements from a resident and two of the resident's daughter's (sic) which allege mistreatment of the resident, by you. The mistreatment rose to the level of mental and psychological abuse as the resident stated that she was fearful, intimidated, humiliated and concerned about reprisal by you. Ms. Beardsley reported this complaint to the State of Wisconsin Caregiver Registry and recommends that you be terminated.

The union case centered on your length of service, the fact that no serious applicable disciplines are in your file, and the fact that you may speak louder than most people, thus this may have been misconstrued. You deny the resident claim that you told her that if she goes to assisted living that she may have a heart attack in her sleep and might die. The union contended that you and the resident just don't get along, and that is fairly obvious. The union believes that your actions do not warrant termination and that a three-day suspension is the highest level of discipline that should be considered.

I concur with Barbara Beardsley's termination recommendation. Your actions as witnessed by an alert, oriented resident and the resident's daughter caused the resident mental anguish, humiliation, and the fear of future encounters with you and the fear of reprisal. This is consistent with mental and psychological abuse of a resident and is grounds for termination.

Therefore, effective March 16, 2010 you are terminated from employment at Brookside Care Center. You may enter the care facility to pick up your last paycheck, turn in your ID, and pick up any personal belongings. Please notify Ms. Beardsley of your intended presence in advance, as terminated employees should refrain from visiting the facility.

Sincerely,

Frances Petrick, RN, NHA

On March 19, 2010, AFSCME steward Kathy Million filed the following grievance:

> (Circumstances of Facts): Employee was following a Feb 2010 issue of Nursing Assistant Monthly inservice pamphlet on encouraging ADL's. Employee was misconstrued by resident + family when attempting to assist Resident in her ADL's to retain as much independence as she is capable of.
>
> (What did management do wrong?)(Article or Section of contract which was violated if any): Section 1.2, 3.5, 3.8 + All Articles and sections that apply. Written statement by management are not true in fact of verbal context.
>
> (Request for Settlement or corrective action desired): Make employee whole.
>
> 1) Restore job
> 1) Cease + desist from above practice
> 2) All benefits restored
> 3) Written answer to grievance

The grievance was denied, and advanced to arbitration. At hearing, the union presented testimony by five of Anderson's colleagues, and the son of a former patient of hers, attesting to the high quality of care she provided. Anderson also testified. The county presented testimony by Petrick, Beardsley, Fesko and Director of Personnel Robert Reidl.

There is one instance in the record of another CNA being disciplined for violating the same work rule provisions as Anderson. On August 13, 2009, Petrick had written to CNA AV as follows:

> You are hereby advised that on August 18, 2009, in the Brookside Care Center conference room, there will be a pre-disciplinary meeting to discuss the charges of unsatisfactory performance. This is a result of an investigation of a patient complaint in which you admitted to telling a resident to "stop whining." The resident also felt berated when you asked the resident why she messed her room up. Your actions are in violation of the Kenosha County Uniform Work Rules, specifically; Work habits 1 and Deportment, 2 and 3.
>
> On July 22, 2009, a discipline was issued for a 3-day suspension from work without pay for violation of County work rules. As a result of the aforementioned performance infractions, you may be terminated from employment at Brookside Care Center, Kenosha County.

You may have a Union Representative present at this meeting.

You are hereby advised that you have the right to a pre-disciplinary meeting to dispute the charges against you. You may waive your right to this meeting and admit that the charges are true. If you waive your right to the meeting, termination may be imposed without further notice or action.

Please contact me at 262-XXX-XXXX if you have questions.

Sincerely,

Frances Petrick, RN, NHA

I hereby waive my right to a pre-disciplinary meeting upon the charges enumerated above, and state that they are true in substance and fact.

The County terminated AV, and the union grieved. On September 28, 2009, James Moore, chair of the county's Administration Committee, wrote Petrick, AFSCME staff representative Nick Kasmer, the local AFSCME secretary and the grievant as follows:

After hearing the presentations by both the union and management, the Administration Committee reached the following decision:

Motion by Supervisor Faraone to consider a five (5) day suspension in lieu of denial. Second by Supervisor Singer. Motion carried.

If you have any questions, please feel free to contact the Personnel Office.

Anderson has received the following discipline:

On August 29, 2005, she received a verbal warning, as follows:

Description of Infraction
"Unsatisfactory Job Performance"
On 8-27-05 a resident's family member requested you to bring her nourishment. You brought half of the nourishment. When the family requested the rest you responded "that you were not her aide," and did not meet the needs of the resident and family.

How to Correct Problem
Treat residents and families with respect and dignity, meet their needs and requests. You are the full-time CNN on the hall, by assigning you to this hall consistently I put my trust in you that you would set the pace for cares, assisting the part-time CNN and residents to feel comfortable. I am disappointed this

happened and won't happen again. Please schedule a review of residents rights (with) Julie Iwen (?)

What Further Discipline May Result
Up to and including termination dependent upon infraction.

On July 12, 2006, Anderson received a written warning, as follows:

Description of Infraction
"Employees shall be courteous and polite @ all times while on duty or while engaged in work related situations"
#1 under work habits
When asked for assistance by another employee on 7/8/06 ~~you responded on 2 different occasions, "Jesus Christ, I'm busy. How stupid can you be"~~ You were not helpful, very rude, commented, "you did jot want to be left with anyone," "Do it this way"

How to Correct Problem
Treat co-workers with respect. Respond in a courteous helpful manner. Be aware residents and family members overhear your comments, this is a poor reflection on our staff and facility. New employees need to be mentored and guided.
What Further Discipline May Result
Up to and including termination.

On October 18, 2007, Anderson received a verbal warning, as follows:

Description of Infraction
Unsatisfactory Job Performance:
On the evening of 10-17-07 when caring for resident JW you presented yourself to the family in an offensive way by the directness and tone of your voice. Telling them they couldn't be in the room while you did cares. They thought they would be helpful in calming her.

How to Correct Problem
We are in a partnership with families in caring for the residents. They know them better than us. If they want to help it's ok. Please work on your approach with families. Maybe a little small talk before directions. 1st family complaint for you. I know you can do better!

What Further Discipline May Result
Up to and including termination dependent upon infraction.

On May 29, 2008, Anderson received a verbal warning, as follows:

Description of Infraction
Unsatisfactory Job Performance:
On May 14, 2008 you were assigned to distribute nourishments to the residents. You did not pass out the nourishments that evening.

How to Correct Problem
To complete all duties as assigned.

What Further Discipline May Result
Up to and including termination depending upon infraction.

POSITIONS OF THE PARTIES

In support of its position that the grievance should be sustained, the union asserts and avers as follows:

> The facts do not support termination because it is unclear what actually occurred on March 9, 2010; Anderson was only attempting to encourage EO as she had been taught, and Anderson's co-workers' testimony shows that the allegations are false.
>
> There were three people in EO's room on March 9 – EO, her daughter and Anderson. It is only EO's daughter who claims Anderson made a comment about EO dying in assisted living. Anderson denies making the statement, and EO did not claim she did. Brookside's own witness, Fesko, testified that EO was lucid and capable of describing what occurred. The fact that EO didn't claim that Anderson made this statement leads one to believe such comment was not made. The burden is on the employer to show that the comment was made and with two of the three people in the room stating that it was not, there is insufficient evidence to prove that it was.
>
> It is also odd that EO's daughter would wait until the following day to file a complaint, rather than confront a supervisor immediately after such a statement. To wait 24 hours puts the veracity of the complaint into question.
>
> Anderson admits she made a comment to EO about her being more compassionate, and regrets that she did so. However, the context – Anderson was very busy and trying to finish other work – needs to be taken into account. While Anderson's manner was not entirely appropriate, her comment was not so far outside the bounds of decency that she should be fired for it.
>
> It appears Anderson is being fired for her general interactions with EO. Anderson is a CNA who pushes her residents to try to be as independent as possible; it is not unprofessional for a nurse to try to encourage this.

The fact that the county reported the incident to state authorities as alleged patient abuse is less significant than the fact that the state experts determined that Anderson's actions did *not* constitute patient abuse.

It is also noteworthy that several of Anderson's co-workers testified that they did not believe Anderson would make the comment she was alleged to have made.

Because the county failed to prove that Anderson made the comment regarding EO having a heart attack there is not enough evidence to support any discipline of her.

Even if just cause exists for some form of discipline, termination is too severe based on the County's policy of progressive discipline, Anderson's file showing no similar offenses, and precedent of a prior case of an employee (who had already been suspended once) engaging in verbal abuse of a resident and only receiving a five-day suspension.

In support of its position that the grievance should be denied, the county asserts and avers as follows:

Lori Anderson was discharged for patient abuse. Progressive discipline is not appropriate in this case because of the severity of the charge. Anderson had been disciplined for a similar situation in the past, and she had also had an altercation with a coworker on the job. Her history reveals Anderson's inability to get along with families and residents; there was something that she said or the tone of her voice that resulted in complaints.

None of the coworkers who testified that Anderson would never abuse a resident witnessed the incident with EO. EO's daughter was, and testified; EO also gave a statement. Lori Anderson was intimidating EO to benefit her own schedule; her acts of abuse were willful because it was her intent to teach EO to use her call button less, dress herself despite doctor's orders, and make her own work day easier. Anderson made statements to EO that made her feel scared and intimidated. EO was totally dependent on Anderson for cares and Anderson complaining to her when she asked for help is cruel.

Anderson confessed she paid no attention to the care plan, but expected the nursing staff to update her. There had been no change since EO's arrival, yet Anderson made her own assessment and demanded the EO perform a task that cause EO paid and was not medically recommended. EO was afraid of Anderson, and afraid to ask for help. The statement that EO's daughter overheard Anderson make to EO about EO returning to Brookside or dying was inappropriate, frightening and a backhanded threat and unfair. As EO's

caregiver, Anderson was unfair, frightening, and intimidating; this type of abuse is insidious.

Discharge is the proper discipline for this patient abuse. County work rules address courteous and disrespectful behavior, as well as physical or verbal abuse or intimidation. Anderson clearly violated work rules as well as state regulations. Her actions and treatment of EO constituted abuse. EO's family was distraught by their mother's fear of and intimidation by Anderson. Nursing staff recognize this treatment as abuse, and had to report the incident to the state, launching an investigation which has caused a mark on Brookside's reputation. EO has suffered lasting effects as the result of this abuse, and is now afraid to ask for help at her new residential facility. Discharge was appropriate.

Anderson had at least one other instance where family members complained about her manner. Anderson was clearly on notice that any similar actions could subject her to termination. The frightening thing is that the gap in her file where there are no complaints was when she tended to the needs of Alzheimer's patients, who presumably would not be able to recall any complaints about her. What Anderson said to EO was mean. She is not only rude, but does not pay attention to care plans. Anderson intimidated EO to such an extent that she no longer asks for help even in her present living situation. Anderson should not work in patient care and certainly not in service to a vulnerable and weak population.

Discharge was an appropriate level of discipline for this offense of patient abuse. Progressive discipline was not warranted. Anderson may not have intended for there to be abuse, but that was the end result of her actions and her attempts to lighten her work load. She should not be caring for vulnerable elderly patients like EO. The discharge should stand, and Anderson should not be reinstated.

DISCUSSION

Patient abuse is an extremely serious matter, and Kenosha County is right to be concerned about it occurring at Brookside Care Center. I agree with Personnel Director Reidl's testimony that, "there is no more serious offense a CNA can make than to abuse a resident." The county is also correct that patient abuse may justify immediate termination, rather than requiring the employer to proceed through progressive discipline. Merely calling Anderson's conduct on March 9, 2010, "patient abuse," however, does not settle the question before me.

As is customary, the parties' collective bargaining agreement authorizes the employer to discipline employees with just or proper cause.[6] It is well-settled that just cause requires that an employee knew particular conduct was forbidden; that the employee knew the potential sanctions for engaging in forbidden conduct; that the employer establish at the arbitration hearing that the employee did in fact engage in the forbidden conduct; and that the level of discipline is appropriate in light of the employee's history and the history of other employees being disciplined for similar offenses. [7]

Anderson has a good history at Brookside. In her 14 years, she has received relatively light discipline (three verbal warnings and one written warning, discussed further below). And, except for her first three months on the job, her performance evaluations have ranged from good to very good, with additional commentary attesting to her competence and care.

Discipline issued to other employees for similar misconduct is an important element in assessing whether the discipline under arbitral review was with just cause. In that regard, the county's discipline of AV in August, 2009 is particularly relevant, and not helpful to the county's cause. AV, who had just been issued a three-day suspension in July, 2009, purportedly admitted telling a BCC resident to "stop whining." Petrick determined this constituted a violation of county work habits 1 and deportment rules 2 and 3 (the same provisions Anderson is accused of violating). Petrick terminated AV for the incident, but the county's Administration Committee reduced the discipline to a five-day suspension.

In its brief, the county sought to downplay the relevance of the AV incident because it was "based on politics," not the merits of the matter. But regardless of *why* the county supervisors on the Administration Committee acted as they did, their actions constituted the statement that the appropriate discipline for telling a BCC resident to "stop whining" is a five-day suspension. Given that AV had been at BCC for only about 5 years (compared to Anderson's 14), and had been issued a 3-day suspension only one month before this incident (more serious than any discipline Anderson ever received), this precedent substantially weakens the county's case for discharge. [8]

Brookside Administrator Petrick's letter terminating Anderson does not specify the precise grounds upon which Petrick based her decision, other than to state Anderson's actions "caused the resident mental anguish, humiliation, and fear of further encounters with you and fear of reprisal." Petrick determined this was "consistent with mental and psychological abuse of a resident," and as such was grounds for termination.

There are several components to the encounter between Anderson and EO on March 9, 2010, as follows:

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[6] The collective bargaining agreement refers to "proper cause" in section 1.2 and "just cause" in section 3.5. I consider the two terms interchangeable.

[7] As Policy Report #139 phrases it, "discipline measures shall all be appropriate to the infraction."

[8] Although Reidl testified that "several" Brookside employees were "terminated for similar activity," the county offered no corroborating evidence.

- Did Anderson tell EO that she should have told her she needed to go to the bathroom before Anderson put the pedals on the wheelchair?

- Did Anderson tell EO that she had a hard job that kept her very busy, and that EO should have some compassion for her?

- Did Anderson direct EO to try to pull her own pants down to go to the bathroom, and to try to put her own socks on? If so, was this appropriate under EO's Plan of Care?

- Did Anderson tell EO that if she went to an assisted living facility, she would soon either have a heart attack and die in her sleep or be back at Brookside?

- Did the encounter leave EO so traumatized that she feared reprisal for reporting the incident, and refrained from using her call light even when she left Brookside two or three weeks later and moved to a new facility?

These specific allegations about the purported events of March 9 must be understood in light of the ongoing relationship between EO and Anderson, which EO and her daughters found extremely unsatisfactory. The statements by EO and her daughters, and daughter Christine Parker's credible testimony, all establish that it was very stressful for EO to be tended to by Anderson – so stressful that EO would sometimes go without care from a CNA rather than risk having Anderson respond to a call for assistance. Certainly, this level of client and family unhappiness reflects, at the very least, deficiencies in Anderson's performance. Failure to meet the reasonable expectations of residents and their families as to courtesy and respect rightly exposes an employee to discipline, as indicated by the relevant work rules. However, since EO and her daughters had not expressed these concerns to Brookside management, and Anderson was thus not aware of any problems in the care she was providing EO, the question is whether Anderson's performance fell so far outside the scope of acceptable conduct as to justify immediate termination. [9]

Anderson acknowledges that several of the allegations against her are true, starting with the acknowledgment that she has a loud and brassy voice. She testified that she did make a comment about the wheelchair pedals being hard to install and remove, and that she wished EO had told her about needing to go to the bathroom before Anderson had put the pedals on. She testified she tried to get EO to put her socks on and remove her pants herself, which Anderson said she felt was appropriate for EO's continuing recovery, based on her understanding of the literature about rehab residents being encouraged to "do things on their own." She testified

[9] While the stress was evidently building in EO and her daughters for some time, there is no indication in the record that they had expressed any concerns to BCC management prior to March 10, 2010. Parker testified this was the first complaint they filed about Anderson, and Fesko testified that this was the first she had heard of their concerns. Anderson had thus not been told prior to this incident that there were problems with her performance regarding EO.

that, "much to my regret," she did tell EO that she was very busy, and that EO should have some compassion for her, which Anderson testified "was inappropriate." Anderson forcefully, almost tearfully, denied telling EO that if she went to assisted living she would likely have a heart attack and die, testifying that she was merely trying to encourage her to stay at BCC.

Anderson has been given three verbal warnings and one written warning in her 14 years at Brookside, but the county attempts to use this relatively light disciplinary record against her. The county calls the extended period during which Anderson suffered no discipline a "frightening thing" because "the gap in her file where there are no complaints" was during her assignment to Alzheimer's patients, who "presumably would not be able to recall" being abused. I explicitly and unequivocally reject this baseless insinuation.

In 2005, Anderson received a verbal warning for failing to bring a resident all her nourishments, and speaking inappropriately to the resident's family. In 2006, Anderson received a written warning, for not being courteous and polite. In 2007, she received a verbal warning, for the "directness and tone" of her voice when she told family members they couldn't be in the resident's room while Anderson did the resident's cares. In 2008, Anderson received a verbal warning for not distributing all nourishments to the residents. There are no other disciplines of Anderson in the record.

The county, by adopting Report # 139, has adopted the policy of progressive discipline, which allows for an escalation of discipline if inappropriate conduct is repeated. However, the escalation must be internally consistent and appropriate.

Here, the county has been inconsistent in applying discipline for related offenses. It is generally understood that a written warning or reprimand is a higher level of discipline than a verbal version. Indeed, Report #139 explicitly states that a verbal reprimand is "the start of progressive discipline," and that a "written reprimand should be used for repetition of an offense that originally caused a verbal reprimand."

Yet the county imposed a *written* warning on Anderson for not being courteous and polite in 2006, followed the next year by a *verbal* warning for the similar offense of an inappropriate "directness and tone" of her voice when barring family members from a resident's room. That is, for the second instance of a similar offense, the county imposed a *less* serious discipline than for the first offense.

Moreover, none of the four disciplines – three verbal warnings and one written warning – even constituted the lowest level of progressive discipline under Report #139, which establishes a verbal reprimand as "the start of progressive discipline."

Certainly, as Report #139 and the common law of arbitration both establish, a single occurrence of egregious behavior can justify termination. The question, therefore, is whether Anderson did in fact commit patient abuse of EO on March 9, 2010.

The State of Wisconsin determined she did not.

As quoted above, both the state and federal definitions of abuse include the important concept that the caregiver's improper conduct is intentional, and done meaning to cause harm or distress to the patient. The state administrative code explicitly states that "an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance" is not abuse. Yet when Petrick was asked on direct examination at hearing if she thought Anderson intended to be committing abuse, she replied, "I don't know what her intent was." This answer seems to weaken the county's case that Anderson's conduct constituted abuse as defined by the relevant statutes and administrative code.

The county asserts that the nursing home staff's reporting of the incident to the state triggered an investigation, "causing a mark on Brookside's reputation." I do not understand how that could be. The state investigated the incident, and determined that it did not constitute abuse. How, then, would this cause a mark on Brookside's reputation? Indeed, it could just as easily be asserted that the incident – which showed the county to be aggressively proactive in reporting possible abuse – burnished, rather than besmirched, BCC's reputation.

By far the most serious allegation against Anderson is that she told EO that if she went to assisted living she would either have a heart attack and die, or soon be back at Brookside. Given Anderson's history, both as to performance and discipline, and the discipline issued to AV, the other aspects of the encounter simply do not justify an immediate disciplinary termination. [10]

There were three witnesses to the encounter on March 9 – Anderson, EO, and EO's daughter Christine Parker. Parker wrote in her statement, and testified at hearing, that Anderson made the comment about EO dying at the assisted living facility or returning to BCC. Parker also testified that by the time in the encounter that Anderson purportedly made this comment, she was already crying because she was so upset at how Anderson was treating and speaking to her mother. Anderson testified at hearing that she did not make such a statement. EO, whom the county described as lucid and competent, did not include the allegation in the statement she gave to supervisory nurse Fesko.

The failure by EO to make any mention of this purported comment highlights a critical error in Anderson's termination letter of March 15, 2010. Brookside Administrator Petrick wrote, "You deny the resident claim that you told her that if she goes to assisted living that she may have a heart attack in her sleep and might die." In fact, nowhere in the record does *the resident* make this claim; it is only her daughter, Parker, who made this claim.

[10] While Beardsley testified she thought Anderson's comments other comments were "inappropriate," it was the purported comment about the implications of EO going to assisted living that Beardsley "felt met the definition of abuse" under federal regulations. Beardsley testified this purported statement "was abusive," and "appalled" her.

Thus, as the union notes, only one of the three witnesses supports the claim that Anderson told EO that if she went to assisted living she would either be back at Brookside or dead within three months. One witness, whom the county witness described as lucid and aware, did not mention the comment in her statement. One witness forcefully denied that the comment was made.

It is natural for a complainant to reaffirm the particulars of a complaint at hearing. It is natural for someone accused of misconduct to deny an allegation. But there is no incentive or reason for a purported victim of misconduct to downplay or even ignore a critical component of the alleged misconduct. Thus, even allowing for the expected self-interest involved in the testimony of Parker and Anderson does not explain away the fact that EO never told Fesko or any other BCC staff that Anderson had made the statement as Parker had alleged.

The county has thus failed to establish by a preponderance of evidence that Anderson made the statement to EO that if she went to assisted living she "may have a heart attack in her sleep and might die." In the words of Policy Report #139, the county did not meet its burden to "be able to sufficiently substantiate the occurrence" of this allegation.

I understand that Parker testified that Anderson's treatment left EO so shaken that she remained reluctant to use her call light, even when transferred to a different facility, and that the county considers this to show that Anderson was engaged in "verbal abuse or intimidation." However, there are at least two problems relying on this testimony to support Anderson's immediate termination. The first is that it is hearsay – Parker's testimony about what EO told her was offered for the truth of the matter; although Anderson had the ability to cross-examine Parker, she was not able to do so with EO. [11] Also, the problems that EO and her daughters perceived in Anderson's care had been building for some time; there is no way to isolate the impact of the events of March 9 from the events of earlier interactions. The allegation that Anderson told EO that if she went to an assisted living facility she would likely soon either be dead or back at Brookside was the only allegation that could have supported a finding that Anderson engaged in "verbal abuse or intimidation" of EO. Therefore, the county did not have just or proper cause to find that Anderson violated Deportment 3 of the County Work Rules.

Anderson did, however, violate Deportment 2 and Work Habits 1. Her comment to EO that she was very busy and that EO should have some compassion for her, and the manner in which she told EO that she should let her know about having to go to the bathroom before Anderson installed the wheelchair pedals were discourteous and impolite. Further, by admittedly not reviewing EO's Plan of Care, Anderson was being disrespectful when she tried to get EO to do more than she was comfortable doing (i.e., putting on her socks and assisting in her toileting).

[11] The record does not indicate whether Anderson's union representatives were able to interview EO at any time during this process.

Accordingly, on the basis of the collective bargaining agreement, the record evidence and the arguments of the parties, it is my

AWARD

1. That Kenosha County did not have just or proper cause to discharge Lori Anderson for violating Work Habits 1 and Deportment 2 and 3 of the County Work Rules;

2. That Kenosha County had just cause to suspend Lori Anderson for ten days for violating Work Habits 1 and Deportment 2 of the County Work Rules;

3. That the disciplinary discharge of Lori Anderson is modified to a ten day suspension;

4. That Kenosha County shall make Lori Anderson whole for lost wages and benefits, minus any wages, payments or benefits Anderson received which she would not have received but for her termination.

5. I shall retain jurisdiction to resolve any disputes about the implementation of this award, unless and until I am released by both parties.

Dated at Madison, Wisconsin, this 6th day of April, 2011.

Stuart D. Levitan /s/

Stuart D. Levitan, Arbitrator

SDL/gjc
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