BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

ALL ABOUT LIFE REHABILITATION CENTER

and

SEIU HEALTHCARE WISCONSIN

Case 1
No. 71227
A-6491

(P.K. Termination Grievance)

Appearances:

Mr. Daniel Finerty, Lindner & Marsack, Attorneys at Law, 411 East Wisconsin Avenue, Suite 1800, Milwaukee, Wisconsin 53202-4498, appeared on behalf of the Employer.

Ms. Summer H. Murshid, Hawks Quindel, S.C., 222 East Erie Street, Suite 210, P.O. Box 442, Milwaukee, Wisconsin 53201-0442, appeared on behalf of the Union.

ARBITRATION AWARD

On November 14, 2011, Service Employees International Union, Healthcare Wisconsin filed a request with the Wisconsin Employment Relations Commission, seeking to have the Commission appoint a member of its staff to hear and decide a grievance pending between the Union and All About Life Rehabilitation Center. Following concurrence from the Employer, the Commission appointed William C. Houlihan, a member of its staff, to hear and decide the matter. A hearing was conducted on February 8, 2012, in Fond du Lac, Wisconsin. No formal record of the proceedings was made. Post-hearing briefs and reply briefs were filed and received by April 10, 2012.

This Award addresses the termination of P.K.

BACKGROUND AND FACTS

All About Life Rehabilitation Center is a part of Extendicare Health Services, Inc. and operates a long term care and rehabilitation facility in Fond du Lac, Wisconsin. Certain of its employees are represented by SEIU Healthcare, Wisconsin and the parties are signatories to a collective bargaining agreement, whose relevant portions are set forth below.

The grievant, P.K., was employed by All About Life, as a CNA for a period of 10 years preceding her termination. Prior to the incident that led to her termination the record indicates that the grievant had been counseled or disciplined on three occasions. On June 10, 2010 the grievant was given a Final Notice for a variety of offenses, including horseplay, verbal abuse or discourtesy to employees, being away from the duty station without authorization, interfering in other employees performance of work, eating residents food, use of profane language, and willful failure to perform the job. Notes from the disciplinary meeting detail the underlying basis for the discipline.

On August 24, 2010 the grievant was given a counseling note. That note provided:

> Follow direction and guidelines of therapy Staff. If therapist requesting something you feel is unsafe report to DON/supervisor immediately. Therapist do "take lead" in transfers, positioning, etc.

It was the grievants' testimony that the resident involved in the August 24 matter was to be transferred using a Hoyer Lift. The staff tried to transfer her with a gait belt, and she fell to the floor. The grievant testified that she was instructed to follow the guideline for transfer, and that if she had questions about resident transfer, to ask her supervisor.

On October 21, 2010 the grievant was given a Discharge Warning for inconsiderate care of a resident. The conduct leading to the discipline included telling a patient that she would be getting a shower and not returning to do so, and failing to get a chair for a visitor, resulting in the visitor standing for the entirety of a visit. The resident quotes the grievant as having said "I don't have time, I have too many other things to do" when asked if she would get a chair.

The grievant contested the accuracy of the claims that led to the discipline and disputes the discipline. However, no grievance was advanced, and I regard the discipline as a part of her record.

The incident that prompted the termination occurred on August 13, 2011. It was the grievant's testimony that she was working that evening when a resident, for whom she was responsible, called for assistance in using the commode. The resident in question was in the facility following knee surgery. The resident was described as overweight and without any mental impairment. The grievant responded to the call, and when she realized the purpose of the visit, got her co-worker, Josie, to help. CNA's are provided with an instruction sheet, referred to as a group sheet, which identifies a care routine for the resident. Included in the residents group sheet was an indication that her transfers were to be accomplished by "2 assist pivot transfer and walker". The resident said "no", and indicated that she wanted to be transferred by a "sit to stand". According to the grievant, the resident indicated that her plan had been changed. The sit to stand is a more secure transfer device.

The grievant was unaware of any change in transfer approach. She left the resident to talk with the Registered Nurse, Mai Xiong, who was supervising her shift. The two returned, and Ms. Xiong asked what the problem was. The resident indicated that she was to use the sit to stand, and Ms. Xiong returned to the Nurse station to review the chart. Once there, she found that the chart had been changed, with the change not having been made to the group sheet. Ms. Xiong indicated that the sit to stand could be used. The grievant secured the sit to stand device, and it was used. The grievant, and others, apologized to the resident for the matter. According to the grievant there was no argument involving herself and the resident. She further testified that the resident did not complain about how she had been treated.

It was the grievant's testimony that she had a history of working with the resident. She indicated that the resident had previously used a sit to stand transfer device. The grievant testified that the therapy had been modified due to arm and shoulder pain experienced by the resident. It was the grievant's testimony that she was both aware of this history and concerned about the potential for pain that caused her to be cautious. By all accounts the resident did not evidence pain on the day in question.

The next morning, a resident concern report was prepared and submitted by a different R.N.. That report provided the following:

> Light on @ 5 AM-5:10? answered light (Both)
>
> Resident wanted to use the commode. "You can't use the sit to stand, they changed it, to use walker or 2A."
>
> "That's' what they wanted me to do, but I know I was to use the sit to stand." She said to check her paper.
>
> "she said I don't get one."
>
> She told them she was not using the walker, only the sit to stand. They blamed it on therapy, they don't let us know. They went and got the RN and she came down also and said to use s-t-s. She, P., went and came back after checking, P. said, they called Darlene and she was right to use the sit to stand.

Darlene Angle is the Administrator of All About Life. When she received the report, she commenced an investigation. She interviewed the resident, who she described as still upset. Ms. Angle testified that the grievant argued with the resident as to which transfer device to use. Angle testified that the resident was within her rights to ask to use a more secure transfer procedure. Ms. Angle's notes of her interview of the resident consist of the following:

> Josie- "Maybe you should lose some weight", said very low, in her room. Over in the corner.

> Apologized like crazy. P. said are you mad at me. P. also said, they are so busy, its just like a Christmas tree out there with all the lights on.
>
> "they made me upset. If I could walk I'd have been out of here a long time ago."
> Resident stated P. also talks about her dates and acts giddy in my room
>
> Resident is fearful of retaliation if they get in trouble.

Ms. Angle interviewed the grievant. Angle testified that the grievant denied that there was an argument and also denied that she ever told the resident that she had called Angle. Angle's notes indicated that the grievant said that she had suggested to the resident that the resident should call Angle.

Angle also interviewed Josie. In the interview Josie denied making any statement about losing weight. She indicated that once the R.N. had authorized the sit to stand they got the sit to stand and did the transfer. Josie indicated that the grievant told the resident that " P. did tell her maybe she should talk to the Administrator on Monday and clear this up with all departments."

Angle interviewed Mai Xiong. Ms. Xiong prepared a summary of the events of August 13. Ms. Xiong's summary is as follows:

> It's toward the end of the shift. Approximately 5 am. CNA P.K. came to get writer and asked if writer can go to talk with resident. Resident is refusing to transfer with stand by assist and is requesting to use sit-to-stand. Writer went with CNA to resident's room and asked resident what's the matter. Resident states she is suppose to be using the sit-to-stand, but the two CNA Josie D. and P.K. refused to do it. Writer reiliterate resident that writer haven't been talking with resident lately, but the last time writer spoke with resident, resident states she wants to walk more. The reason she doesn't get strong quicker was we don't walk her enough. Resident states it's correct, but she just had a meeting with the care team and they advised her to use sit-to-stand for now. As writer and resident were talking, CNA Josie D. said "where is your proof?" Resident asked "what proof" Josie D. "the paper said that you can use sit-to-stand" Resident "I don't have it" Writer told resident writer wasn't sure about resident's currently transfer status because writer hasn't been on team 2 for a while, but will go and check. Resident asked where is writer going to check? Writer respond that she will check resident's paper on her chart. Writer went to check chart. On resident's transfer, lifting, positioning sheet, it said resident is to use sit-to-stand with transfer as of 8/11/11. Writer went back to resident's room and informed resident. Apologized for misunderstanding/confusion and told CNA to use sit-to-stand. Writer left room with CNA P.K. as she's getting

> the sit-to-stand lift. Writer have zero knowledge of what happen as the not writer not present. Mai Chia Xiong

Ms. Xiong also testified at the hearing. Her testimony largely confirmed her written statement. She further indicated that as an R.N., she delegates resident care, and has disciplinary authority over the CNA's should that be necessary. She testified that residents have a right to refuse treatments and that if CNA's have questions relating to resident care they are to come to her. She further testified that the resident did not complain that day, nor indicate that she was unhappy. Ms. Xiong was not advised that there had been an argument. She testified that there was no report of resident pain that day. Ms. Xiong testified that the CNA should come to the R.N., with concerns even under circumstances where the resident was asking for a greater degree of protection than was required, because the R.N. has to evaluate such a request. She testified that if the care plan called for a 2 assist and a walker, the CNA was required to follow the plan.

Following the investigation, Angle determined to terminate the grievant, and did so. The Disciplinary Action Report, which summarized the basis for discharge, indicates that the grievant had provided "Inconsiderate care of any resident/patient…not considered by management to be abuse."

It described the events leading to discharge as:

> P. attempted to transfer patient (___) with 2 assist and walker but patient wanted to use sit-to-stand. Per patient, P. argued and finally went to get the nurse to intervene. When P. returned to the room she told patient that she had called the Administrator and "she said to use the sit-to-stand." P. did not call me, there is no reason to believe this patient is confused or disoriented. Patient also stated that P. is "giddy" when in her room and talks about her boy friend and her dates which is more than patient wants to know. Patient stated that P. returned to room later and apologized and blamed it on Therapy for not letting them know changes and asked her if she was mad at her.

ISSUE

The parties stipulated the issue to be:

Was the grievant discharged for just cause, per Sec. 15.01 of the parties 2010-2013 collective bargaining agreement?

Of not, what is the appropriate remedy?

RELEVANT PROVISIONS OF THE COLLECTIVE BARGAINING AGREEMENT

ARTICLE III – GRIEVANCE AND ARBITRATION

. . .

Section 3.3 – The decision of the arbitrator shall be final and binding on both parties. The arbitrator has no authority to add to, subtract from, modify, or ignore any provision of this Agreement.

. . .

Section 3.6 In cases alleging resident abuse or resident neglect, the arbitrator will draw no inference of any kind whatsoever from the failure or inability of a resident to appear and testify.

Section 3.7 In cases of discipline or discharge proving resident abuse or resident neglect, the arbitrator's determination shall be limited solely to ascertaining whether or not the employee was, in fact, guilty of the acts with which charged by the Employer. The arbitrator, finding such guilt to exist, shall not have the authority to substitute his judgment for that of management as to the penalty imposed.

. . .

ARTICLE XV – SUSPENSION, DISCHARGE, RESIGNATION

SECTION 15.1 – The Employer will have the right to discharge, suspend or discipline any employee for just cause. The Union acknowledges the disciplinary procedure(s) set forth in the Employee Handbook (dated 5/09).

RELEVANT PROVISIONS OF THE EMPLOYEE HANDBOOK

GROUPS OF OFFENSES AND ASSOCIATED PENALTIES

Class I Offenses: Examples of these offenses include, but are not limited to: (other offenses may also merit these penalties)

. . .

Class II Offenses: Examples of these offenses include, but are not limited to: (other offenses may also merit these penalties)

. . .

9. Inconsiderate care of any resident/patient of the facility not considered by management to be abuse.

. . .

Penalties for Class II Offenses:

First Offense: Final Notice
Second Offense: Discharge Warning
Third Offense: Discharge

Class III Offenses: An employee will be discharged if an investigation reveals they have committed a Class III infraction. Other offenses may also merit discharge. Class III examples include, **but are not limited to:**

1. Verbal, mental, physical, or sexual abuse of any resident/patient of the facility, family member, visitor, or fellow employee, or neglect or mistreatment of any resident/patient of the facility.

POSITIONS OF THE PARTIES

It is the position of the employer that the grievant had been provided progressive discipline in the area of resident care and that the grievant simply did not respond. The employer contends that the grievant was informed of expectations; do not be argumentative, provide the care requested by the resident unless it is unsafe, and never tell a resident you are too busy or do not have the time. It is the view of the employer that the resident told a credible story, and there is no reason to question the resident's account of the events. In a facility that provides care for a vulnerable population the standards for workplace behavior must be set higher than normal.

It is the view of the employer, citing the Union's opening statement, that the stipulated issue should be modified to a determination as to whether or not the grievant's behavior constitutes a violation of a class 2 rule. To decide this issue, the employer contends that its determination that the grievant's conduct constituted "inconsiderate care" should be sustained if it was reasonable, and not arbitrary, capricious, and unreasonable.

The employer reviewed the grievant's prior discipline record and concluded that the behavior was a continuation of prior unacceptable behavior. It is the employers view that the grievant could have, and should have exercised her judgment and training to comply with the residents request that the more safe transfer device be used.

It is the view of the Union that the grievant did not commit a class II violation, and therefore there is no basis for her discharge. The Union argues that the Group Sheet reflects

the medical determination as to how the resident is to be cared for. In this instance, that includes the method of transfer. It is the view of the Union that the CNA's are not to exercise independent judgment as to resident care. Rather, they are to follow the group sheet or direct their concerns to a supervisor or R.N. It is the view of the Union that when confronted with a resident who wanted to change the transfer method contrary to the group sheet, the grievant did exactly what she should have done; she went to the R.N.

The Union points to the testimony of a number of witnesses, including Ms. Angle, that employees have been disciplined for a failure to follow the group sheet. The Union speculates that had the grievant deviated from the group sheet, used the sit-to-stand and somehow caused injury to the resident, she would have been disciplined.

The Union argues that the grievant and her co- worker, Josie, were involved in the same incident. The grievant was given a class II violation and discharged. Josie was given a class I violation, which was subsequently withdrawn. It is the view of the Union that the treatment was disparate.

DISCUSSION

The issue before me is the issue stipulated by the parties. The stipulated issue addresses Article XV of the collective bargaining agreement, which is the contractual provision regulating discharge.

I do not believe the grievant provided inconsiderate care to the resident. In essence, the grievant was discharged for arguing with the resident, and for failing to promptly provide the form of care requested by the resident. It is the view of the employer that the sit-to-stand transfer is a safer transfer technique than the 2 assist pivot transfer. In the view of the employer the request for such a transfer is to be honored without question or hesitation.

The investigation that led to the termination was initially prompted by the R.N. resident concern report. There was evidently enough concern by the resident to cause such a report to be prepared. The report indicates that that there was an exchange over the proper transfer device. The noted conversation talks about the change to walker. It does not indicate an argument occurred. The quoted portions of the conversation are consistent with the grievant's testimony as to what occurred. It records only a brief exchange, where the resident acknowledged they wanted her to use the walker, but suggests to the CNA's that they check her paper. It is that context that the conversation over the group sheet occurred. The group sheet that the CNA's were working from had the walker listed as the transfer approach.

There is nothing in the report to indicate an argument had transpired. The report does not indicate that the tone of voice or comments of the grievant were either threatening or disrespectful to the resident. The R.N. who submitted the report did not testify.

The report quotes the resident as indicating that "they" called Darlene. This aspect of the report no doubt captured Ms. Angle's attention. The report does make clear that the R.N. came to the room and authorized the use of the sit-to-stand. It appears that the alleged call to Darlene was reportedly to have occurred after the grievant went to get the R.N..

The report prompted Ms. Angle to conduct an investigation. At the outset, Angle knew that the resident was upset enough to have complained, and that there was no call to her. Angle's interview with the resident confirmed to her that the resident was still upset, that there was an argument between the resident and the greivant, and that the resident was, or became, aware that there was no call to her (Angle). Ms. Angle's notes reflect that the grievant apologized, that the resident complained about other behaviors of the grievant, and that the resident was still upset. Notably, they do not reflect the existence of an argument. They do reflect a comment about losing weight, attributable to Josie, that could be taken as demeaning by the resident.

Angle interviewed the grievant, who denied that there was an argument and further denied saying that she called Angle. Rather, the grievant indicated that she suggested to the resident that she call Angle. Angle's interview notes with Josie indicate the following:

> I asked if she heard P. say she had called the Administrator she stuttered a bit and hesitated and then said "P. did tell her maybe she should talk to the Administrator on Monday and clear this up with all departments." I asked Josie if she had spoken to Pam re. this she replied she had spoken to no one since she just got a new phone and just finished charging it.

Angle interviewed Mai Xiong. The statement from her interview indicates that the R.N. understood that the resident was to walk more in order to get stronger. The only remark from the Xiong statement that appears confrontational or argumentative is the "where is your proof" response Josie had to the resident's assertion that she had met with the care team. From Xiong's statement and testimony, it appears that as soon as the resident told the R.N. and CNA's that the sit-to-stand had been indicated by the care team, they went to look and accommodated her request.

There is no account of the exchange between the resident and the grievant that suggests an argument. The resident has so described it to Angle, but the accounts suggest a short purposeful exchange between the two. The two eyewitnesses deny that an argument occurred. If the exchange was inappropriate, it would seem that the accounts of the exchange would reflect that fact. The notes were made to document a resident complaint and potential discipline of an employee. If the central tenant of the complaint was the existence of an inappropriate exchange or argument, the absence of a reference to the objectionable conduct is puzzling. The only documented disagreement relative to the transfer device is the statement of R.N. Xiong which reports a conversation involving herself, the resident and Josie.

The employer believes the grievant should have honored the request without questioning the resident. However, all witnesses who testified indicated that the group sheet was to be followed. On cross examination Ms. Angle indicated that if the CNA had a question as to the patient treatment, health or if she didn't understand the sheet, she was to contact the R.N.. All witnesses testified that employees have been disciplined for a failure to follow the group sheet. In fact, the grievant was previously disciplined for her failure to follow the group sheet transfer plan. Ms. Xiong, the R.N. with disciplinary authority over the grievant, testified that the grievant was required to follow the group sheet until the R.N. reviewed a request for change, evaluated the request, and approved the change. Her testimony in this respect specifically included a request to use a safer device.

I believe the grievant acted out of concern for the resident, and not out of some desire to avoid work or to be insensitive to the residents wishes. The care plan had been changed from a sit-to stand. The record supports a finding that the staff wanted the grievant to walk more. The grievant testified that the resident had previously experienced pain with the sit-to-stand. There is no evidence that the grievant acted in a disrespectful way with the resident. The investigation documents two potentially inappropriate remarks; the "lose some weight", and "where's your proof" comments. Both are from sources that Ms. Angle has credited. Neither is attributed to the grievant.

The resident concern report and the Disciplinary Action Report both indicate that the grievant advised the resident that she had called Angle. The grievant and Josie deny that the grievant had made the statement. It was the testimony of all witnesses that the grievant went to get R.N. Xiong, who came into the room, was advised of a change in the care plan, checked the plan and authorized the sit-to-stand. Ms. Xiong's statement was that the resident asked what they were checking and was told they would check her chart. There was no reason to call the administrator. No such call was made. It is unclear why the grievant would then tell the resident that "they" had made such a call.

It appears that the grievant did attribute the confusion to therapy not making her aware of the changes. In fact, the group sheet was not updated to reflect the change in the care plan. The grievant's testimony that she told the resident that she should call the administrator to have the matter cleared up is consistent with the underlying fact that the group sheet was wrong.

The grievant testified that she had never been shown the resident concern report prior to the hearing. She could not have known of the alleged call to the administrator from that report. She was asked by Angle whether she advised the resident that she had made such a call during her interview. Josie was asked the same question and provided the same answer. While it is possible that the two employees talked between interviews, determined to deny what was said, and offered an alternative, there is nothing in the record to support such a conclusion. The interviews appear to have been conducted on the same day. Josie was asked if she had talked with the grievant, and denied doing so. It is at least as likely that the two eye witnesses to the conversation recounted what they saw and heard.

In conclusion, I do not believe that the grievant provided inconsiderate care to the resident. The resident was aware of a change in the care plan. The grievant was not. The circumstance that led to the confusion was the fact that the group sheet was not updated. That is not attributable to the grievant. The record does not support the employers' contention that the grievant should have honored the grievant's request for a safer transfer device without question. Nothing in the record suggests that the grievant treated the resident with a lack of respect or courtesy. The intemperate remarks that were made were not made by the grievant, and were regarded as Class I offenses. The record does not support a finding that the grievant advised the resident that she had called the Administrator.

AWARD

The grievance is sustained.

REMEDY

The Employer is directed to reinstate the grievant and to make her whole for lost wages and benefits. The Employer is further directed to expunge her personnel file of any reference to this discharge. The Employer is entitled to offset the back pay with interim earnings and/or Unemployment Compensation, if any.

JURISDICTION

I will retain jurisdiction over this matter for a period of 30 days to resolve any dispute over the remedy.

Dated at Madison, Wisconsin, this 19th day of July, 2012.

William C. Houlihan /s/
William C. Houlihan, Arbitrator

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