BEFORE THE ARBITRATOR

In the Matter of a Dispute Between

SEIU HEALTHCARE WISCONSIN

and

OAKWOOD LUTHERAN HOMES

Case ID: 440.0018
Case Type: A

AWARD NO. 7973

(Akeem Msiska Discharge)

Appearances:

Nicholas Fairweather, Attorney, Hawks Quindel, S.C., 409 E. Main Street, P.O. Box 2155, Madison, Wisconsin, appearing on behalf of SEIU Healthcare Wisconsin.

Jon Anderson, Attorney, Husch Blackwell LLP, 33 East Main Street, Suite 300, Madison, Wisconsin, appearing on behalf of Oakwood Lutheran Homes Association, Inc.

ARBITRATION AWARD

SEIU Healthcare Wisconsin (hereinafter referred to as the Union) and Oakwood Lutheran Homes (hereinafter referred to as Oakwood or the Employer) were parties to a collective bargaining agreement that provided for final and binding arbitration of unresolved grievances. Pursuant to the parties' request, the Wisconsin Employment Relations Commission appointed the undersigned to decide the instant grievance. A hearing on that grievance was held via Zoom on February 12, 2021. The hearing was not transcribed. The parties filed briefs on March 26, 2021, whereupon the record was closed. Having considered the evidence, the arguments of the parties, and the record as a whole, the undersigned issues the following Award.

ISSUE

The undersigned frames the issue as follows:

Did the Employer violate the terms of the collective bargaining agreement when it discharged the grievant? If so, what is the appropriate remedy?

PERTINENT CONTRACT PROVISIONS

The parties' March 1, 2019 – February 28, 2021 collective bargaining agreement (CBA) contained the following pertinent provisions:

* * *

ARTICLE 34 – DISCHARGE AND CORRECTIVE ACTION

> 34.1 Just Cause. The Employer may discharge or suspend a Staff member for just cause. If requested, a Work Site Leader will be called in when a Staff member meeting may result in disciplinary action up to and including discharge. If a bargaining unit member is denied a Union representative for an investigatory meeting in which he or she is entitled to Weingarten rights, no discipline will be issued regarding that incident.

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BACKGROUND

Oakwood Lutheran Homes operates Oakwood Village. Oakwood Village is a continuing care retirement community in Madison, Wisconsin. It provides a continuum of care from lowest level of care, independent apartment living to assisted living to the highest level of care, skilled nursing, based on the needs of its residents. Oakwood has two campuses. There is a West campus known as University Woods and an East campus known as Prairie Ridge. The employee involved in this grievance worked on the West campus (University Woods).

The Union represents the service and maintenance employees employed by the Employer at its East and West campuses. One of the job classifications in the bargaining unit is CNA (certified nursing assistant). CNAs are responsible for providing personal care to residents including bathing them and changing their briefs.

Oakwood expects its employees to treat all residents entrusted to it with respect and dignity. Employees of Oakwood know the responsibility that they have to care for the residents who live there, whether they are in assisted living or in skilled nursing. Employees are trained to care for the residents. To that end, they receive training in protection of resident rights and how to do their jobs in a respectful and non-abusive manner. They receive regular refreshers and in-service training in the care and treatment of residents. It is not considered acceptable behavior for an employee to put their hand over a resident's mouth or to tell them to shut up. That would be considered abusive and impermissible behavior.

Akeem Msiska worked as a CNA at Oakwood for 16 years. He is of African descent and English is not his first language. Prior to the incident involved here, he had never been charged

with patient abuse. Additionally, prior to the incident involved here, he had a clean disciplinary history meaning he had not previously been formally disciplined.

FACTS

This case involves the treatment of CH, an 84 year old female. CH is a resident in Hebron, a skilled nursing facility on the University Woods campus. Her diagnosis is vascular dementia with a behavioral disturbance diagnosis. Vascular dementia presents as a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain. Symptoms are confusion, disorientation, and trouble speaking. Additionally, she has agitation and combativeness. While CH can speak certain words, she is unable to speak coherently, or engage in conversation, or communicate. She regularly yells and screams. She is one of Oakwood's most vulnerable residents. As such, she cannot care for herself and is totally dependent on Oakwood's employees for all of her care and needs.

About dinnertime on June 8, 2020, CNA Breanna Dement tried to change CH's briefs, but was unsuccessful in doing so because CH was combative. Dement then left CH's room and asked Msiska to help her with that task. Msiska agreed to do so. Msiska did not normally work with CH but had worked with her before.

At the time, Dement knew that Msiska was a long term employee whereas she had been at Oakwood for two years. They were neither friends nor enemies; they were simply coworkers. They had worked together before. Msiska described his working relationship with Dement as good and Dement said she had no history of conflict or bad blood with Msiska.

These facts are undisputed. After Msiska agreed to help Dement with CH, they both reentered CH's room together. When they did so, CH was yelling and screaming because she was still agitated from Dement's previously unsuccessful attempt to change her briefs. Dement and Msiska then worked together to change CH's briefs. To do that, they were on opposite sides of CH's bed. It took about five minutes to accomplish this task.

What else happened during their interaction with CH is disputed. There were three people present in the room who were eyewitnesses: CH, Dement and Msiska. CH did not testify at the hearing. Thus, Dement and Msiska were the only witnesses with actual first-hand knowledge who testified about the interaction with CH.

Msiska testified that as he went into CH's room he told her to "calm down" in a normal tone of voice. He testified he did not put his hand over CH's mouth, or tell her to "be quite lady" or to "shut up." He also testified that a nurse, Suad, was in the hallway near CH's room when he and Dement were in CH's room.

Dement testified that as they entered CH's room, CH was screaming, whereupon Msiska put his hand over CH's mouth to cover her screaming and said words to the effect of "be quiet lady" or "shut up" and laughed. Dement testified that CH could still breathe with Msiska's hand over her mouth, but the loud sound she was making was muffled by Msiska's hand. Dement

testified that Msiska held his hand over CH's mouth for several minutes as CH flailed about and unsuccessfully attempted to remove Msiska's hand from her mouth. Dement testified she was shocked by what she witnessed, but did not say anything to Msiska at the time about it or try to remove his hand. Additionally, Dement did not say anything immediately afterwards to any supervisor about it.

Later that day, Dement told another CNA, Olivia Walters, what had happened during her and Msiska's interaction with CH. Dement did not tell Walters this in person, as Walters was not working at Oakwood at the time. Instead, Dement sent a text message to Walters with this information in it. This was unusual for several reasons. First, Dement and Walters do not normally text each other messages. Second, the two had no history of talking about Msiska. In any event, Walters replied to Dement's text and said that Dement should report what she had seen to management. When Walters later returned to work at Oakwood, she incorrectly assumed that Dement had told the administration about the matter with CH. As a result, Walters did not report the CH matter to anyone.

Two days later on June 10, 2020, Dement reported the CH incident to Kacy Riley, Oakwood's Director of Nursing, via an email. Dement's email to Riley said in pertinent part:

> He [Akeem] went on the other side of the bed and put his hand over her mouth saying "be quiet lady." This continued during the duration he was in the room which was a few minutes. 232 was trying to pull his hand off her mouth.
>
> I know I should have stepped up to say something to Akeem but felt awkward as he has been working here for a while and tends to have his own ways of doing things. My intent of this email is not to get him in trouble, but to let you know as it doesn't sit right with me.

Riley was on vacation and away from the facility when Dement sent this email to Riley's work email account. As a result, Riley did not open or see Dement's email until she returned to work on June 15, 2020. After Riley open the email on the morning of June 15 and read its contents, she forwarded it to Oakwood's Administrator, Kim Blum, who immediately started an investigation and notified the State (specifically, DHS) of the incident with CH.

At part of its investigation, management officials first obtained written statements from Dement and Msiska. Then, management officials interviewed Dement, Msiska and Walters, plus all the staff who were working at the time of the incident (about a half dozen employees). The Employer's Director of Social Services also tried three times to have a conversation with CH about the matter, but each time CH was non-communicative because of her dementia.

After Dement and Msiska were interviewed, both were placed on suspension pending the completion of the Employer's investigation. After the Employer completed its investigation, it accepted Dement's version of the facts concerning what happened to CH and determined that Msiska told the resident to "shut up" and held his hand over the resident's mouth for several minutes.

On June 17, 2020, Oakwood's Administrator sent an email to all staff regarding resident abuse prevention. The memo provided in pertinent part:

> Important Reminder:
>
> If you witness resident abuse or neglect, the FIRST step is to ensure the resident's safety and stay with the resident until the situation is safe. Once safe, it is important to tell someone immediately 24/7. This can be to a RN on duty, Charge Nurse, DON, RN on call or NHA. The Nursing Home Administrator is responsible to submit a Department of Health Services Misconduct incident report within 24 hours of a report of abuse.

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On June 18, 2020, Oakwood discharged Msiska. His discharge notice provided in pertinent part:

> Violation of staff standards for conduct and performance policy – Co-worker reported abusive behavior toward Hebron resident (CH-room 232) on 6/8. Investigation conducted and DHS state report submitted.

Dement received a "second written warning" for her delay in reporting Msiska's conduct to management. Additionally, the Employer required her to take additional training before she was allowed to return to work.

The record shows that management "reeducated" Walters about how the Employer wants abuse allegations reported.

Msiska subsequently grieved his discharge and the grievance was appealed to arbitration.

After he was fired, Msiska reached out to his former coworkers and asked them to write letters of support on his behalf. A half dozen of them did. Those testimonials praise Msiska's overall character and describe him as a dedicated employee.

DISCUSSION

The issue to be decided here is whether the Employer had just case to discharge Msiska. I find that it did. My rationale follows.

I'm first going to look at the applicable contract language. It is found in Section 34.1 of the CBA and says that "[t]he Employer may discharge or suspend a Staff member for just cause." This language obviously subjects employee suspensions and discharges to a just cause standard.

The threshold question is what criteria is going to be used to determine just cause. The phrase "just cause" is not defined in the CBA, nor is their contract language which identifies what the Employer must show to justify the discipline imposed. Given that contractual silence, those decisions have been left to the arbitrator. In their brief, the Employer cites what is known in labor relations circles as the Daugherty standard for determining just cause and essentially invites me to apply it here. I'm not going to do that. I only apply the Daugherty standard when the parties jointly ask me to do so and that did not happen here. Consequently, I'm going to apply the standard I've applied in hundreds of disciplinary cases. It involves addressing these two elements: first, did the employer prove the employee's misconduct, and second, assuming the showing of wrongdoing is made, did the employer establish that the discipline which it imposed was commensurate with the offense given all the circumstances.

Since this is an alleged patient abuse case, I've decided to begin with the following general comments about that topic. Patient abuse in a nursing home is an extremely serious matter because of the home's legal obligation to care for its residents. The home must protect its residents along with its reputation. Failure to do so would be to the detriment of all persons connected with the operation. That being so, it is clear that the Employer has a legitimate concern with, as well as a direct interest in, preventing patient abuse.

Next, building on that, I'm going to start my discussion with the premise that CNAs are not supposed to walk into a room where the resident is already screaming and say "shut up lady" and then put their hand over the resident's mouth for several minutes to muffle the scream. The reason I'm starting with that premise is because the Employer avers that that conduct constitutes patient abuse. I concur. Simply put, that is both verbal and physical abusive behavior. As such, it should not occur.

That said, the question in this case is whether that conduct occurred to resident CH on June 8, 2020. The Employer contends that it did, relying on Dement's testimony that Msiska did the two things just noted. The Union contends it did not occur, relying on Msiska's testimony that he did not do either of the two things just noted.

Given the foregoing, I obviously have to decide which witness to believe and which testimony to accept. In doing so, I'm faced with the proverbial he said, she said situation.

Before I make my credibility call, I'm going to review some factors that I typically consider when making a credibility call. First, in some credibility cases, one of the persons involved has a history of being untruthful. Here, though, that was not shown to be the case. Second, in some credibility cases, one of the persons involved has a history of similar behavior. Since this case involves alleged patient abuse, it would be noteworthy if Msiska had previously been charged with patient abuse. However, prior to this case, he had no history of patient abuse at Oakwood. That is particularly noteworthy when one considers that he's been a CNA there for 16 years. Third, in

some credibility cases, there is a history of animosity or bad blood between the people involved. When that is the situation, it obviously gives them a basis for potential bias which could color their testimony. Here though, there is no history of animosity or bad blood between Msiska and Dement. Finally, in some cases, there are other witnesses who saw something that can corroborate the testimony of the main participants. That is not the case here. While CH obviously was there, she is not capable of telling us what happened because of her dementia. Additionally, residents don't typically testify in patient abuse cases, particularly in cases like this one where they are the alleged victim. That means no one else can corroborate the testimony of either Dement or Msiska. The statement which the Union offered by nurse Suad Zidani was not helpful because she did not see or hear the conduct at issue and was not in the room when it happened. The absence of the foregoing factors here makes making a credibility call in this case difficult.

Nonetheless, for the following reasons, I have decided to credit Dement's account of what happened to CH. First, her testimony at the hearing about what happened on June 8, 2020 to CH was confident, direct, not evasive and consistent with the prehearing statements she made to management about the incident. In contrast, Msiska appeared to be rattled by Dement's testimony, and was not as calm or direct when he testified. Also, when he testified at the hearing, he said that he told CH when he came into her room to "calm down", but that detail was not mentioned in either his written response to management or in his interview with them. Also, when he testified at the hearing, he did not specifically respond to Dement's claim that his hand over CH's mouth while she was screaming created a muffled sound. One would think that Msiska would have addressed that point in his testimony and offered another plausible explanation for that unusual sound being generated. However, Msiska did not offer any other explanation for the source of the sound that Dement testified she heard.

Second, after the incident occurred, Dement told coworker Walters about what Msiska did to CH. This was significant because it shows that Dement thought what happened to CH was not the normal, run of the mill changing of briefs that CNAs do all the time. Instead, this one was different, and Dement decided to confide in a workplace friend about it. While that happens in workplaces every day, what was somewhat unique was this: Walters was not at work at the time so Dement did not tell Walters face to face. Instead, Dement composed a text message and sent it to Walters. This was not something Walters and Dement did often. We don't know what facts Dement included in her text message because it was not offered into evidence, but we do know that it ended with Dement asking Walters what she should do. While the Union sees the fact that the text message was not offered into evidence as significant, I do not. In my view, its absence from the record is of no consequence.

Third, while Dement ultimately followed Walters' recommendation and reported the matter to management, that happened later than it should have. The Employer wants to hear about abuse allegations immediately. Here, though, it took Dement two days to work up the courage to report it. The fact that it took her that amount of time to tell management about Msiska's conduct actually strengthened her testimony because it shows that she wrestled with whether or not to report Msiska for his conduct. After all, he was a long term very experienced employee while she was not. While her delay in reporting was wrong, it reflects that she weighed the significance of turning in a coworker with her knowledge of why reporting was required and that his conduct was wrong.

Fourth, no evidence was offered why Dement would make up charges against Msiska and his conduct on June 8, 2020 and subsequently falsely testify against him in the instant hearing. As already noted, there was no showing of any animosity between Dement and Msiska, and Msiska himself said that he had a good work relationship with her. That being so, there is no apparent reason for Dement to lie or fabricate her account of the incident with CH. In contrast, Msiska does have an obvious reason to lie or fabricate, to wit: he's trying to save his job. That weakens his credibility. Dement gained nothing by reporting what she had witnessed. If she had said nothing to management, she would not have been disciplined because management would have been unaware of what happened. However, she had to have known when she reported Msiska's conduct two days later that she herself would be disciplined for both not stopping the conduct when it occurred and for reporting it to management later than it should have been. While Dement was ultimately given a second written warning for those two things and required to take additional training before she returned to work, Dement did not know what amount of discipline the Employer would impose on her. That being so, the easier course of action would have been for her not to report Msiska's conduct. She did though. Once again, the fact that she did so while not knowing what discipline awaited her enhanced her overall credibility as a witness.

After considering all the foregoing collectively, I find Dement's account of the interaction with CH is more plausible than Msiska's. I therefore reach the same conclusion as the Employer did, and find that notwithstanding Msiska's denial, he did indeed say "shut up lady" to CH and then put his hand over her mouth for several minutes to muffle her screaming.

Having concluded that the incident occurred as alleged by the Employer, the next question is whether that conduct constituted workplace misconduct warranting discipline. It did. Patient abuse in a nursing home is obviously grounds for disciplinary action. It is a very serious offense.

* * *

The focus now turns to the second part of the just cause analysis being used here, namely, whether the Employer established that the penalty imposed for this misconduct was appropriate under all the relevant facts and circumstances. Quite frankly, this is the part of the case that I struggled with the most. That's because prior to the five minute incident with CH, Msiska was a long term employee with no history of patient abuse and no prior discipline. Additionally, the written testimonials from Msiska's coworkers which are part of the record praise his overall character and describe him as a dedicated employee. While the Employer obviously could have chosen a form of discipline less severe than discharge because of the circumstances just noted, it decided to discharge him. I have decided to not overturn that decision for the following reasons. First, Oakwood has discharged other employees for patient abuse. Prior to this case, the most recent example occurred in 2019. In that instance, employee EB physically pushed a resident in frustration. The record does not contain any instances where an employee physically abused a resident and was not discharged. In this case, the Employer decided to take that same hard line with Msiska that it had taken in other patent abuse cases. Contractually speaking, it could do that because there is nothing in the CBA that precludes the Employer from taking that position. Second, Msiska was not subjected to any disparate treatment in terms of the punishment imposed. While

the Union cited a number of instances where employees at Oakwood received discipline less severe than discharge for various acts of misconduct, none of those cases involve facts or misconduct involving physical patient abuse that are remotely comparable to what happened here. That's because in none of the cases that the Union cited did the employee place their hand over the mouth of a resident for several minutes and tell them to shut up (as Msiska did with CH). Thus, none of the cases cited by the Union is a true comparable to the facts of this case. Accordingly, then, it is held that the severity of the discipline imposed here (i.e. discharge) was neither disproportionate to the offense, nor an abuse of management discretion, but rather was reasonably related to the seriousness of Msiska's proven misconduct. The Employer therefore had just case within the meaning of Article 34.1 to discharge him.

In light of the above, it is my:

AWARD

That the Employer did not violate the terms of the CBA when it discharged the grievant. Therefore, the grievance is denied.

Issued at Madison, Wisconsin, this 16th day of April 2021.

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Raleigh Jones, Arbitrator