BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between	Case 3 No. 46829 A-4871
GENERAL TEAMSTERS UNION, LOCAL NO. 662	
and	Case 4 No. 46836 A-4872
THE CLAIREMONT NURSING FACILITY	

Appearances:
Previant, Goldberg, Uelmen, Gratz, Miller & Brueggeman, S.C., Attorneys at Law
Weld, Riley, Prenn & Ricci, S.C., Attorneys at Law, 715 Barstow Street, P.O. B

ARBITRATION AWARD

General Teamsters Union, Local No. 662, hereinafter the Union, and The Clairemont Nursing Facility, hereinafter the Employer or Facility, are parties to a collective bargaining agreement which provides for final and binding arbitration of grievances arising thereunder. Pursuant to a request for arbitration, the Wisconsin Employment Relations Commission appointed the undersigned to hear two grievances involving discipline imposed on employe Nancy Henke. A hearing was held in Eau Claire, Wisconsin on March 26, 1992. The hearing was not transcribed. The record was closed on May 18, 1992, upon receipt of the parties' post-hearing briefs. Based on the entire record, the undersigned issues the following award.

ISSUES

The parties stipulated to the following issues:

First grievance

Did the Employer violate the parties' collective bargaining agreement by suspending the grievant for three days, to wit, October 28, 29 and 30, 1991? If so, what is the appropriate remedy?

Second grievance

Did the Employer violate the parties' collective bargaining agreement by discharging the grievant on January 6, 1992? If so, what is the appropriate remedy?

PERTINENT CONTRACT PROVISIONS

The parties' 1991-93 collective bargaining agreement contains the following pertinent provisions:

ARTICLE 11

DISCIPLINE AND DISCHARGE

Section 1. Basis. No employee shall be disciplined or

discharged except for just cause. Employees shall have the right to be represented by a Union representative in connection with any investigatory meeting with an Employer representative regarding disciplinary action.

Section 2. Records. Personnel records, including warnings and disciplinary measures taken, shall be dated. Employees may request to see their own personnel record and reasonable access to the same shall be made available. When authorized by the employee, the Union shall be afforded the same opportunity.

Section 3. Disciplinary Procedure. The progression of disciplinary action normally is 1) oral, 2) written, 3) suspension, 4) dismissal. However, this should not be interpreted that this sequence is necessary in all cases, as the degree of discipline will depend on the severity of the offense. Disciplinary actions shall be maintained in effect for eighteen (18) months during which time a repetition of the same or similarly serious offense can result in more serious disciplinary action. In all such cases the employee shall have the right to recourse to the grievance procedure.

Section 4. Notice. A suspension or discharge shall be effected in writing by the Employer, with copies delivered to the employee and the Union steward. Grievances protesting a suspension or discharge must be filed within seven (7) days from delivery of the written notice or the right to grieve same shall be forfeited. Grievances filed as a result of a suspension shall commence at Step 3 of the grievance procedure and grievances filed as a result of a discharge shall commence at Step 4. By mutual agreement of the parties, Step 3 can be waived and the parties can proceed directly to arbitration.

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ARTICLE 13

EMPLOYEE RESPONSIBILITIES

Section 1. In General. It is understood that because the nature of the Employer's service is the providing of care for the aged and infirm, the Employer has a right to expect that employees will be especially sensitive to the many and varied special needs of the Employer's residents and will at all times conduct themselves in a completely patient, courteous and considerate manner, consistent with maintaining the dignity and self-esteem of such residents. Since the health and general welfare of the residents is and should be the paramount concern of all parties, it is recognized that the standards of behavior towards residents, as established by the Employer, unless shown to be unreasonable by a clear preponderance of the evidence, must be strictly adhered to. Any breach of those standards shall subject an employee to disciplinary action, up to and including discharge.

. . .

Section 3. Resident Abuse. The parties agree that any act or failure to act by an employee which constitutes abuse of a resident or patient under either the Wisconsin Statutes or any administrative rule adopted pursuant thereto, or any violation of a resident's or patient's rights as defined in either said statutes or rules, shall be considered good cause for immediate discharge. An arbitrator appointed hereunder shall have authority to modify or set aside such discharge only if it is established by clear convincing evidence that the Employer acted in bad faith in connection therewith.

BACKGROUND

These two grievances concern the Employer's three-day suspension and subsequent discharge of employe Nancy Henke, a 12-year veteran nursing assistant employed at The Clairemont Nursing Facility in Eau Claire, Wisconsin. Henke was the union steward and served on the Union's bargaining committee that negotiated the current contract which is the first between these parties.

In the 18 months prior to her discharge, Henke received the following discipline: 1/ a formal oral warning on June 7, 1991 for taking too long a

1/ The Employer also relies on a written warning Henke received for "neglecting the needs of a resident", specifically, "failing to respond to a resident's call light." However, contrary to the Employer's assertion, that warning was issued May 15, 1990, not May 15, 1991. That

break; a written warning on July 17, 1991 for twice taking her lunch break at unauthorized times; and a one-day suspension on August 8, 1991 for refusing to come to work on one of her days off when the Facility was short-staffed. The suspension was grieved and later reduced to written warning without back pay. On September 9, 1991, she was suspended for three days for neglecting a resident's needs (specifically, failing to take a wheelchair-bound resident to the bathroom when requested). The suspension was grieved and appealed to arbitration. In an award dated April 7, 1992, the arbitrator found that this suspension was without just cause and that the Employer had violated the parties' collective bargaining agreement by suspending Henke for three days. The arbitrator directed the Employer to remove the three-day suspension from Henke's personnel file and to make her whole for all wages and benefits which were lost as a result of the suspension. The parties were awaiting this award when the instant hearing was held.

FACTS

The October 16, 1991 Incident

Shortly after noon on October 16, 1991, Henke was passing out food trays to the patients. Upon entering the room of patient A.U., Henke discovered that the patient had had an extremely messy bowel movement in her bed. The patient, an obese woman, was covered with soil from her feet to her shoulders, much of which had dried on her body and on the bed. Henke then left the patient's room and encountered Carmen Bassing, a charge nurse, in the hallway. Henke told Bassing that A.U. was very soiled and was a "big mess". Henke also told Bassing that "Bob", another nursing assistant, knew that the patient was a mess. Bassing responded by telling Henke to go tell Marcella Jordan of the problem, which she did. Bassing never directed Henke to clean up the soiled patient.

Jordan, another charge nurse, was in charge of a team which included the nursing assistant (identified at the hearing only as "Bob") to whom A.U. was assigned. Henke told Jordan that A.U. was "full of poop", that she (Henke) could not feed the patient in that condition, and that A.U. was another aide's responsibility so she (Henke) would not clean up the patient. Jordan never directed Henke to clean up A.U. Jordan testified the reason she did not direct Henke to clean up A.U. was because Henke seemed "stressed out." Jordan later directed "Bob" and another nursing assistant to clean up A.U., which they did via a sponge bath.

Jordan reported this incident to her supervisor, Verdella Anderson, who in turn reported it to Director of Nursing Bonnie Ackley. Ackley then began an investigation into the matter to determine the facts. In the course of this investigation Ackley interviewed Jordan, Anderson and Henke for their accounts of the matter. All their accounts were as identified above. When Ackley interviewed Henke, Henke told Ackley she did not clean up the soiled patient because she was a big mess and because that patient was assigned to another nursing assistant.

On October 25, 1991, Henke was suspended for three days (specifically October 28, 29 and 30, 1991) for her "conduct" on October 16, 1991. The employe warning form which notified Henke of the suspension stated:

> Refused to clean up a resident that had a bowel

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being the case, this warning had evaporated pursuant to Article 11, Section 3 by the time Henke was discharged.

movement - said she's a mess and she is not my patient. Did not feed her because she was full of B.M. Resident was cleaned up by 2 other NAs.

The suspension was grieved and appealed to arbitration.

The record indicates that each nursing assistant at the Facility is assigned a certain number of patients and the nursing assistants are responsible for assisting them with their daily living needs. One of the nursing assistant's job tasks is to clean up messy patients. It is normal procedure at the Facility for a nursing assistant who finds a messy patient to clean them up, even if that patient is not assigned to that nursing assistant. This unwritten procedure is known informally as "you find it - you clean it up." An exception to this "you find it - you clean it up" procedure exists for large messes, but the exact scope of the exception is unclear. Henke and Ruth Garr, another nursing assistant, testified respectively that if a patient is a large mess or badly soiled, the clean-up is to be done by the nursing assistant to whom the patient is assigned. Ackley and Bassing testified that when a patient needs a shower (to clean up the mess), then the clean up is to be done by the nursing assistant to whom the patient is assigned.

The January 6, 1992 Incident

In the morning of January 6, 1992, Henke and Ruth Garr were working together in the "300 hall" of the Facility. Garr took her morning break first while Henke continued to work. When Garr returned, Henke signed out and went on her break. As Henke walked toward the break room, she noticed that a patient's call light was on at the nurses' station which is across the hall from the break room. This call light indicated that a patient in the "200 hall" had requested assistance from a nursing assistant. Henke did not respond to the call light but instead walked into the break room where three nursing assistants (Lucy Schrawder, Jeanne Berg, and Bryan Kell) were about to end their break.

What Henke told the assembled nursing assistants is disputed. Henke testified she collectively told them (i.e. the three nursing assistants in the break room) that a (call) light was on and someone in the 200 wing needed assistance, whereupon all three of these nursing assistants left the room. Nursing assistant Lucy Schrawder testified that when Henke walked into the break room, she said "C.R. is calling 'nurse's aide, nurse's aide'." Henke disputes this and testified she did not see C.R.'s call light or hear her (C.R.) call out.

Schrawder, Berg, and Kell then left the break room together and Schrawder, the nursing assistant assigned to C.R. that day, attended to C.R. C.R.'s room is about two rooms away from the break room. C.R. is an elderly resident who is incontinent and known to frequently call for assistance when she thinks she might soil herself or her bed. On this occasion, C.R. felt the need to go to the bathroom and that is why she turned on her call light. Schrawder assisted C.R. by putting her on the commode.

Later that day, nursing director Ackley received a phone call from the daughter of C.R. The daughter reported that she had been talking on the telephone with C.R. that morning when C.R. needed to go to the bathroom. The daughter reported that C.R. turned on her call light and, when no one responded, C.R. began calling out for a nursing assistant to help her. The daughter reported that C.R. continued to call out for a nursing assistant (while she was on the phone) until a nursing assistant arrived to take her to the bathroom. Following this phone call, C.R.'s daughter came to the Facility in person and registered a complaint with Ackley that the staff was not

responding promptly to her mother's call for assistance.

Ackley then began an investigation into the matter to determine the facts. In the course of this investigation Ackley interviewed Henke and the three nursing assistants present in the bathroom when Henke came in (Schrawder, Berg and Kell). Henke and Schrawder's accounts were as identified above. Berg and Kell, who did not testify at the hearing, signed statements indicating that Henke announced to them (as she walked into the break room) that: "C.R.'s light was on and she was yelling" (Berg) and "I think C.R. needs to go to the bathroom" (Kell).

After conducting this investigation, the Employer credited the account of the three nursing assistants present in the break room over Henke's account and concluded that Henke, when she started her break, was aware that C.R.'s call light was on and that C.R. was calling for assistance but that Henke nevertheless took her break anyway and let another nursing assistant (Schrawder) assist C.R. Ackley determined that this conduct constituted a failure to respond to the needs of a resident and she discharged Henke for "resident neglect" that same day. The form which notified Henke of her discharge stated:

> During investigation of a family/resident complaint, it came to my attention that at times the resident needed to call out for help to try to avoid bowel movement accidents. When speaking to N.A.'s about this, I was made aware that Nancy Henke heard/was aware of resident's need and did not respond to the resident's needs. Nancy has been previously talked to regarding her attitude of not meeting the needs of residents.
> /s/ Bonnie Ackley
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> Because this constitutes resident neglect termination is deemed necessary.

The discharge was grieved and appealed to arbitration.

The record indicates that it is normal procedure at the Facility for nursing assistants to respond to patient's call lights and/or calls for assistance, even if they are not assigned to that patient.

POSITIONS OF THE PARTIES

The Union's position is that the Employer did not have just cause to suspend and discharge the grievant. It makes the following arguments with regard to the suspension. First, it begins by noting that Henke was suspended for "refusing to clean up a resident that had a bowel movement. . ." According to the Union though, Henke did not "refuse" to clean up the patient because she was never ordered to do so by either Bassing or Jordan. Since neither supervisor ordered or directed Henke to clean up the soiled resident, the Union contends Henke never "refused" to clean up the patient. Next, the Union argues that in handling the situation with the soiled patient, Henke was simply following the normal, accepted and routine procedure for encountering a very messed-up resident, to wit: reporting it to a supervisor and continuing with the work which the nursing assistant was previously performing and the clean up is done by the nursing assistant to whom the messed-up patient is normally assigned. It notes in this regard that this is exactly what happened in this instance since the nursing assistant assigned to the soiled patient did, in fact, clean up the patient with the help of another nursing assistant. Third, the Union submits that the Employer overreacted to the relevant events. In its view, the grievant's discussing how to handle the patient with a supervisor and

the resultant short delay in beginning the clean-up process is not resident abuse. Finally, the Union asserts that there was no intent by the grievant to harm the patient and no adverse consequences resulted. The Union believes that if the grievant's suspension is upheld, this would gut the just cause provision of the contract. It therefore requests that the arbitrator overturn the suspension and issue a make-whole remedy. With regard to Henke's discharge for alleged "resident neglect", the Union makes these arguments. First, it argues that the Employer's handling of the discharge violated fundamental notions of due process because the Employer gave Henke no opportunity to rebut the statements made against her and failed to conduct a reasonable, fair and impartial investigation prior to deciding to fire her. The Union notes that where employers fail to conduct a proper investigation prior to imposing severe punishment, arbitrators have not hesitated to overturn the discharge penalty. The Union urges the arbitrator to do likewise here. Next, the Union contends that the credible facts do not establish any "patient abuse or neglect". It notes in this regard that Henke immediately notified the nursing assistant assigned to C.R. that she (C.R.) needed some help and that nursing assistant responded. In the Union's opinion, the brief delay that occurred between these occurrences (i.e. Henke telling the nursing assistant assigned to C.R. of C.R.'s need for assistance and that nursing assistant responding to C.R.'s needs) does not warrant discharge. Finally, the Union argues that permitting a discharge under the instant circumstances would violate the progressive disciplinary sequence established in the contract. It notes in this regard that Article 11 of the labor agreement provides a progressive disciplinary sequence. Since Henke's first suspension was just vacated by another arbitrator, the Union believes the proper progressive disciplinary sequence was not followed here. It therefore requests that the discharge be overturned and the grievant reinstated and made whole.

It is the Employer's position that it did not violate the collective bargaining agreement by suspending the grievant in October, 1991 and discharging her in January, 1992. In its view, both the suspension and the discharge were proper under the circumstances and were for just cause. According to the Employer the grievant engaged in misconduct on both occasions, to wit: refusing to clean up a resident that had a bowel movement (in the first instance) and failing to respond to a resident's call light and cries for help (in the second instance). In the Employer's opinion, both incidents constituted patient abuse and/or neglect. With regard to the first incident, the Employer asserts that the resident smeared with her own feces should have been immediately cleaned up by the grievant, no matter how distasteful the situation was. The Employer believes that the grievant's failure to do so and leaving the resident in that pitiful state was not an adequate response. It notes in this regard that any nursing home permitting such a response to situations of this nature would be subject to severe discipline by the regulatory agencies. Additionally, it contends that the failure of nurse Jordan to order the grievant to clean up the resident is not a justification for the grievant's refusal to do so. In its view, no such direct order was needed in this instance because the grievant knew her duty - she just did not do it. With regard to the second incident, the Employer asserts that the grievant's conduct (i.e. failing to respond to a resident's call light and cries for help) was resident abuse within the meaning of both state law and the labor agreement. According to the Employer, this instance alone was sufficient to warrant the grievant's discharge. It notes in this regard that absent a finding of bad faith, the labor agreement requires that discharge for patient abuse must be upheld by the arbitrator. In its view, there is no evidence in this record on which it could be found that the Employer acted in bad faith, so it submits that the discharge should be upheld. The Employer argues in the alternative that even if the contract's "resident abuse" provision is inapplicable to this instance based on the premise that the grievant's failure to respond to the resident was not resident abuse, it was still the last in a

long series of work-related infractions which, when considered in light of her prior record, warranted discharge. The Employer believes it meticulously complied with all of its contractual obligations in the discipline meted out to the grievant and the discharge was the logical and proper last step. It submits that whatever quantum of proof is applied by the arbitrator, the Employer has met it. Finally, the Employer asserts that the fact that the grievant's September, 1991 suspension was just overturned by another grievance arbitrator should not have a material bearing on subsequent discipline because the offenses involved here are factually distinguishable from the September, 1991 incident. The Employer therefore contends that both grievances should be denied and the penalties upheld.

DISCUSSION

The Suspension

Article 11 governs the first issue, and requires that the Employer have just cause to suspend the grievant. The elements to a just cause analysis have been variously stated. In my opinion, where the agreement does not specify the standards and where the parties have not otherwise stipulated to them, the just cause analysis must address two elements. The first is that the Employer demonstrate the misconduct of the grievant and the second, assuming this showing is made, is that the Employer establish that the penalty imposed was justified under all the relevant facts and mitigating circumstances.

The grievant was suspended for "refusing to clean up a resident that had a bowel movement. . ." Refusing or failing to clean up soiled residents 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, ensuring that all its residents receive proper care. The issue here regarding the first element of the just cause determination turns, then, not on the Employer's interest in ensuring that residents receive proper care, but instead on whether the grievant "refused to clean up a resident" as charged.

This call obviously turns on the facts involved. What happened here was that the grievant was delivering food trays when she encountered a resident who had had an extremely messy bowel movement in her bed and was covered with soil. The grievant did not clean up the resident or start the process. Instead, she left the resident's room and told two separate charge nurses, Bassing and Jordan, of the resident's condition. She also told Jordan (the second charge nurse she encountered) that she would not clean up the patient because the patient was another aide's responsibility. Neither Bassing nor Jordan directed or ordered Henke to clean up the soiled patient.

It is noted at the outset that nursing assistants at the Facility are responsible for cleaning up patients who have such accidents, even if the soiled patient is not assigned to the nursing assistant. This unwritten procedure is known informally as "you find it - you clean it up." There is no question that Henke failed to comply with this procedure here since she found the soiled patient but did not clean her up. Instead, Henke just left the patient in the same condition she was in when Henke walked into the room. Additionally, insofar as the record shows, Henke did not tell the patient before leaving the room that help would be forthcoming or set a timetable for same. It can therefore be said that Henke did not respond either physically or verbally to the patient's condition.

The latter is addressed first. In the opinion of the undersigned, the

patient was entitled, at a minimum, to a verbal response from the grievant. By that, I mean an acknowledgement that she was aware of the patient's condition and although she was not going to do the work herself, someone else would soon. In my view, it was not appropriate for the grievant to simply walk away from the patient without letting her know that help (i.e. clean-up) was on the way.

Having said that, attention is now turned to the grievant's failure to respond physically to the patient's needs. The reason Henke failed to comply with the "you find it - you clean it up" rule in this instance and clean up the patient herself was that she believed it was not her job to clean up the soiled patient. In her opinion, this particular instance fell within an exception to the aforementioned rule. Witnesses testified at the hearing that an exception to this "you find it - you clean it up" rule exists for large messes, but they disagreed over its exact scope, to wit: Henke and Garr testified that when a patient is a large mess or badly soiled, then the clean-up is to be done by the nursing assistant to whom the patient is assigned, while Ackley and Bassing testified it is only when a patient needs a shower (to clean up the mess) that the clean-up is to be done by the nursing assistant to whom the patient is assigned. The undersigned believes he does not need to decide which of the foregoing views accurately identifies the scope of the exception to the "you find it - you clean it up" rule. Rather, what is important here is that an exception to the "you find it - you clean it up" rule exists, and that Henke believed the situation she found, namely an obese woman covered with dried soil from her feet to her shoulders, fell into the exception. Henke made her position known to both Bassing and Jordan when she told them that she believed "Bob" (the nursing assistant to whom the soiled patient was assigned) was responsible for cleaning up the soiled resident. The Employer disagreed. In its view, this situation did not fall into the exception to the general rule and therefore Henke was responsible for cleaning up the resident herself.

It is apparent from the foregoing that a fundamental conflict existed between Henke and her supervisors concerning who was responsible for cleaning the soiled resident. Simply put, Henke had one view and her supervisors had another. In situations such as this where an employe has one view of who is to do certain work or how it is to be accomplished and the Employer has a different view, it is incumbent upon the Employer to make the decision and advise the employe accordingly with specific instructions. If that is done and then the employe fails to comply, the Employer certainly has a legitimate beef with the employe for failing to comply with a work directive. This is because it is a cardinal rule in the workplace that employes are to obey work orders and do what they are told regardless of whether or not they agree with it.

What happened here though is that supervisors Bassing and Jordan never gave the grievant a specific order or directive that she was to clean up the soiled patient. That being the case, the grievant cannot be said to have actually "refused" to clean up the patient when, in point of fact, she was never directed to do so. In making this finding the undersigned disagrees with the Employer's assertion that a direct work order was not needed in this instance because the grievant knew she was to clean up the soiled patient. In my view, a direct order was necessary in this particular instance for several reasons. First, by Jordan's own admission, Henke was "stressed out" at the time over the resident's soiled condition and the quality of care that resident had received that day from the nursing assistant assigned to her. Second, Henke made it emphatically clear from the outset that she believed another nursing assistant (i.e. "Bob") was responsible for cleaning up the soiled resident because of the size of the clean-up job. Given the foregoing, I believe it was incumbent upon management representatives to clear up any confusion that existed for Henke right then and there concerning who was responsible for cleaning up the resident. They could have done this by giving

Henke a direct order to clean up the soiled resident. However, since no such work order was ever given to Henke, the Employer should not have disciplined her for "refusing" to do certain work (i.e. clean up a resident) when, in fact, she was never ordered to do it. Consequently, it is held that the Employer did not have just cause to suspend the grievant and her suspension must therefore be nullified.

The Discharge

Attention is now turned to the grievant's discharge. The standard utilized by the undersigned in reviewing the discharge depends on which of two different contractual sections is found to be applicable to the January 6, 1992 incident. The Employer points to the resident abuse clause (Article 13, Section 3) and contends it is applicable to that incident while the Union points instead to the progressive discipline clause (Article 11, Section 3) and argues its applicability here. This distinction is important since the former (i.e. the resident abuse clause) limits the protection granted in the latter (i.e. the progressive discipline clause). This is because the resident abuse clause provides that "resident abuse" is grounds for summary (immediate) discharge. It is implicit from this section that the normal progressive disciplinary sequence identified in Article 11, Section 3 is inapplicable to such a (patient abuse) situation. Additionally, this section goes on to provide that absent a finding of bad faith, the discharge of an employe for "resident abuse" must be upheld by the arbitrator.

Deciding which of the foregoing sections is applicable here can be said to be the proverbial $64,000 question. This call obviously turns on the facts involved.

Certain basic facts in the January 6, 1992 incident are undisputed and are as follows. When Henke took her morning break that day and walked into the break room, she knew that a patient in the 200 hall of the Facility needed assistance because she saw that a call light was on at the nurses' station across from the break room. Henke did not respond to the call light but instead went on break. As Henke walked into the break room she said something (exactly what is disputed) collectively to the three nursing assistants who were then in the break room. Almost immediately after Henke entered the break room, the three nursing assistants then in the room left as their break was over and returned to work. One of those nursing assistants, Lucy Schrawder, then attended to the needs of the patient whose call light was on in the 200 hall.

What is disputed is what Henke told the three nursing assistants in the break room as she entered. Henke testified she collectively told the three nursing assistants that a (call) light was on and someone in the 200 wing needed assistance. Schrawder testified that when Henke walked into the break room, she said "C.R. is calling 'nurse's aide, nurse's aide'". Henke disputes this and testified she did not see C.R.'s call light or hear her (C.R.) call out.

After weighing this conflicting testimony, the undersigned concludes that Schrawder's testimony that Henke walked into the break room and said "C.R. is calling 'nurse's aide, nurse's aide'" should be credited for the following reasons. First, no evidence was offered why Schrawder would make up this statement and testify falsely against Henke. There was no showing of any animosity between Schrawder and Henke. Thus, there is no apparent reason for Schrawder to lie or fabricate her account of the incident. In contrast though, the grievant is trying to save her job. Second, Henke did not challenge Schrawder's veracity or offer any facts to support her position, but instead simply gave a blanket denial to Schrawder's account of the incident. Third, Schrawder's account was corroborated by what the two other nursing assistants

wrote in their written statements of what Henke said when she walked into the break room. In contrast though, no witnesses corroborated the grievant's account of what she said. Given the foregoing then, the undersigned credits Schrawder's testimony which establishes that Henke knew when she went on her break that C.R.'s call light was on and that C.R. was calling for assistance.

The Employer decided that the aforementioned conduct (Henke's going on break knowing a resident's call light was on and that the resident was calling for help and letting another nursing assistant respond to the resident) was "resident neglect." In its view, "resident neglect" is tantamount to "resident abuse." This conduct will now be reviewed to determine if it constitutes "resident abuse." If it does, then as previously noted Article 13, Section 3 governs the matter. On the other hand, if this conduct is found to not constitute "resident abuse", then Article 11 governs the matter.

Article 13, Section 3 provides in pertinent part that "any act or failure to act by an employee which constitutes abuse of a resident or patient under either the Wisconsin statutes or any administrative rule. . .shall be considered good cause for immediate discharge." This section does not define "resident abuse" per se, but instead incorporates by reference the State's definition of same. The State's definition is found in Section 132.13, Stats., and provides as follows:

> 1. "Abuse" means any single or repeated act of force, violence, harassment, deprivation, neglect or mental pressure which reasonably could cause physical pain or injury, or mental anguish or fear. (Emphasis added)

Under this definition, patient "neglect" constitutes "resident abuse." Neglect however is not defined in either the statute or in the corresponding administrative rules.

Stating the statutory definition of abuse is much easier than applying it, especially in neglect cases. Obviously, varying degrees of neglect can exist in a nursing home. For example, at one end of the spectrum are those situations where a nursing assistant does not attend to the needs of a resident for a long period of time and causes the resident actual physical harm. At the other end of the spectrum are those situations where a nursing assistant does not attend to the needs of a resident for a short period of time, simply keeps the resident waiting and causes no physical harm.

In my view, the grievant's conduct on January 6, 1992 was closer to the latter end of the spectrum than the former, and consequently was not "resident abuse" within the meaning of the contract. This finding is based on the following rationale. It is noted at the outset that Henke did not respond to C.R.'s call light and calls for help by physically going to the resident and seeing what she needed. She should have however in accordance with the Employer's standard operating procedure of nursing assistants responding to call lights. Having said that, Henke did not totally neglect the resident. She mitigated her failure to respond personally by telling the three assembled nursing assistants in the break room of the resident's need for assistance immediately upon entering the break room. One of those nursing assistants (Schrawder) was assigned to care for that resident (C.R.). Immediately upon being told this by Henke, Schrawder left the break room and attended to the resident's needs, specifically taking her to the bathroom. This means that while Henke failed to follow normal procedure and care for the resident herself, she nevertheless did ensure that the resident in question got help by telling Schrawder of the situation who, in turn, provided the needed help. The Employer essentially dismisses Henke's actions as insufficient. In its view,

Henke should have responded to the call light herself rather than simply informing Schrawder of the problem. Had that happened (and Henke responded to the call light herself), it seems logical to presume that the patient would have received care quicker than was the case here. Said another way, it seems logical that the patient would have been attended to sooner if Henke rather than Schrawder had responded. However, the presumption that the resident would have received care quicker if Henke rather than Schrawder had responded cannot be applied here for the simple reason that Bryan Kell's statement of the incident indicated that Schrawder "was exiting the break room" when Henke told her of C.R.'s request for assistance. This means that Henke must have been walking into the break room just as Schrawder was walking out. That being the case, it stands to reason that any delay that occurred because Schrawder rather than Henke responded to C.R.'s needs would have to be measured in seconds rather than minutes. While seconds are certainly of the utmost importance to an incontinent person who is trying to avoid an accident, as was the case here, the fact remains that what was involved here was a delay of a few seconds in response time. In my opinion, this short delay in response time does not rise to the level of "resident abuse", especially when such a finding means that the penalty for same is automatic discharge (unless the arbitrator finds evidence of employer bad faith). It is therefore held that Henke's conduct, though culpable misconduct, was not "resident abuse" within the meaning of Article 13, Section 3. This of course means that the "resident abuse" clause in the contract does not govern the instant matter.

Having so found, it follows that Article 11, Section 3 (the progressive discipline clause) governs the matter. As previously noted, the first component of a just cause analysis requires a demonstration of the grievant's misconduct. This component has been established by the holding in the previous paragraph that the grievant's failure to respond personally to C.R.'s call light and calls for help was misconduct and a disciplinable act. It is therefore held that the Employer had just cause to discipline the grievant for the very reasons noted by the Employer in the disciplinary notice dated January 6, 1992.

The second component of a just cause analysis requires that the Employer establish that the discipline imposed (i.e. discharge) was justified under all the relevant facts and mitigating circumstances. Said another way, the punishment must fit the crime. The Employer argues it has met that burden and that the grievant's prior disciplinary record justifies its decision to discharge. I disagree. In my view, the penalty of discharge for the aforementioned misconduct was excessive. To begin with, the undersigned does not believe the grievant's misconduct on January 6, 1992 constituted a so-called cardinal offense justifying summary discharge without regard to the grievant's past work record. Next, the grievant's past record, while certainly not exemplary, shows that the grievant was only at the suspension step, not the discharge step, for the next infraction. While the grievant had received three suspensions in the applicable 18 month period (a one-day suspension and two three day suspensions), none can be used here for the purpose of justifying (under progressive discipline) the grievant's discharge. This is because the one-day suspension was later reduced by agreement of the parties to a written warning without backpay. For purposes of determining progressive discipline here, this discipline is considered a written warning, not a suspension. The other two three-day suspensions have been nullified in arbitration (one by another grievance arbitrator and the other by the undersigned in the first grievance in this award). That being the case, the grievant does not have any suspensions on the books so to speak. This means that the next step in the contractual progressive disciplinary sequence for the grievant was a suspension. The undersigned finds that the grievant's misconduct on January 6, 1992 warrants a three-day suspension. Consequently, the grievant's discipline is reduced from a discharge to a three-day suspension.

Based on the foregoing and the record as a whole, the undersigned enters the following

AWARD

First grievance

That the Employer violated the parties' collective bargaining agreement by suspending the grievant for October 28, 29 and 30, 1991. The Employer shall make the grievant whole for any losses incurred as a result of the suspension and remove any reference to it from the grievant's personnel file.

Second grievance

That the Employer violated the parties' collective bargaining agreement by discharging the grievant on January 6, 1992. The grievant's discharge is hereby set aside and reduced to a three-day suspension. The Employer shall reinstate the grievant immediately and, but for a three-day suspension, make her whole for all lost wages and benefits less any interim earnings.

Dated at Madison, Wisconsin this 25th day of June, 1992.

By Raleigh Jones /s/
Raleigh Jones, Arbitrator