State of Wisconsin
Labor and Industry Review Commission

Susan F. Brunette, Complainant **Cardinal Ridge Residential Care, LLC** Respondent ERD Case No. C4201403684	**Fair Employment Decision** **Dated and Mailed:** February 22, 2019

The decision of the administrative law judge is **reversed**. Accordingly, this matter is **remanded** to the Equal Rights Division for a hearing on the merits.

By the Commission:

/s/
Georgia E. Maxwell, Chairperson

/s/
David B. Falstad, Commissioner

Procedural Posture

This case is before the commission to consider the complainant's allegation that the respondent retaliated against her for engaging in conduct protected by the Health Care Worker Protection Act (hereinafter "HCWPA"). An administrative law judge for the Equal Rights Division of the Department of Workforce Development held a hearing and issued a decision dismissing the complaint for lack of probable cause. The complainant filed a timely petition for commission review of that decision.

The commission has considered the petition and the positions of the parties, and it has reviewed the evidence submitted at the hearing. Based on its review, the commission makes the following:

Findings of Fact

1. The respondent, Cardinal Ridge Residential Care, LLC (hereinafter "respondent"), operates an assisted living facility in Green Bay, Wisconsin.

2. The complainant, Susan Brunette (hereinafter "complainant"), began working for the respondent on June 14, 2013 as a personal care worker.

3. The complainant's job duties included providing direct personal care to the respondent's residents and cleaning the residents' rooms. She was paid $9 per hour.

4. The complainant's supervisor was Karen Bain, the respondent's administrator. Ms. Bain was responsible for all disciplinary decisions relevant to this matter.

5. During the course of her employment the complainant received numerous warnings and disciplinary actions for a variety of infractions including, but not limited to, missing staff meetings, failing to clean rooms properly, texting a co-worker to complain about work, and making medication errors.

6. In February of 2014, after the complainant had received a number of written reprimands but continued to make medication errors and engage in other unsatisfactory conduct, the respondent considered terminating her employment, but ultimately decided not to do so. Instead, the complainant was issued a five-day suspension and placed on 90 days' probation.

7. Thereafter, the respondent issued additional disciplinary warnings to the complainant, culminating in a final written warning for medication errors on October 30, 2014. This final warning indicated that the complainant would no longer be allowed to administer medications and that during times when medications were being passed the complainant would be assigned other work. At the hearing Ms. Bain testified that "things had calmed down" with the complainant

regarding other matters, so she decided to just take her off the medications rather than terminate her employment.

8. During the course of her employment the complainant had a number of concerns about how the respondent treated its residents. For example, she believed that an employee had violated the rights of a resident by taking pictures of the resident and showing them to a doctor. In another instance, the complainant had observed an employee slam a resident into a wheelchair, telling her to shut up and stop acting like a 2-year old. The complainant also believed that an employee was deliberately closing the blinds in the dining room to make residents think it was night time so she could get them to bed right after dinner and avoid providing additional care. The complainant also observed employees drop medications on the floor and then give them to residents.

9. In September of 2014 or shortly before, the complainant informed Ms. Bain about some of her concerns. The complainant told Ms. Bain that if the State of Wisconsin Department of Health Services (DHS) ever found out what was going on at the respondent's facility they would probably get shut down.

10. In early September, shortly after her conversation with Ms. Bain, the complainant called DHS and made an anonymous complaint about the respondent's treatment of residents. However, DHS took no action. On November 4, 2014, the complainant called DHS again and was told that no action had been taken because she did not leave a telephone number and they did not know how to get in touch with her. The following day, November 5, 2014, representatives from DHS came to the respondent's facility unannounced to conduct an investigation. No one from DHS spoke to the complainant while they were at the facility, but Ms. Bain called the complainant at home that evening and left a voicemail message telling her that someone from DHS would probably be calling her to ask questions. DHS representatives returned the following day, November 6, 2014, to complete the investigation, but did not question the complainant.

11. The complainant told some of her co-workers she had called DHS, but she did not tell Ms. Bain. A DHS representative informed Ms. Bain that DHS had received an anonymous complaint, but could not share who had made the call.

12. On November 12, 2014, Ms. Bain telephoned the complainant at home and told her that she was not required to attend the monthly staff meeting later that day. The complainant asked if this meant she was being fired. Ms. Bain responded that the complainant's employment was being terminated. When the complainant asked why, Ms. Bain referenced the high number of reprimands that had been issued to the complainant.

13. Ms. Bain prepared discharge paperwork for the complainant. The discharge notice (written on a form entitled "Notice of Written Warning") indicates that staff members told Ms. Bain they no longer wanted to work with the complainant and provided written statements to that effect.[1] The form was dated November 12, 2014. On the employee's signature line, Ms. Bain indicated that the complainant had refused to sign. However, the complainant was never shown a copy of the discharge notice.

14. A note attached to the discharge notice indicates that on November 10, 2014, the laundry room door was left propped open with a jug of bleach, in violation of state codes requiring that the laundry room be kept locked at all times. The note, which does not specify that the complainant was the individual responsible for propping the door open, indicates that repeat offenses could be grounds for further discipline and includes a line for the complainant to sign. The complainant never saw the note.

Conclusions of Law

1. There is probable cause to believe that the respondent retaliated against the complainant for having engaged in conduct protected under the HCWPA.

Memorandum Opinion

The question presented in this case is whether the complainant established probable cause to believe that she was discharged in retaliation for having engaged in protected conduct under the HCWPA.[2] The standard of proof required to

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[1] No written complaints from other workers are attached to the discharge notice. The only written complaint presented at the hearing was dated July 24, 2014, and was ostensibly written by an employee by the name of Sandra Gill. However, Ms. Gill appeared at the hearing and testified that she could not recall having written the statement and that the signature did not appear to be hers. Ms. Gill testified, without rebuttal, that after the complainant was discharged the respondent asked employees to write negative statements about her, but Ms. Gill thought the complainant was a good caregiver and refused to do so.

[2] The HCWPA provides, in relevant part:

> (2) REPORTING PROTECTED. (a) Any employee of a health care facility or of a health care provider who is aware of any information. . . that would lead a reasonable person to believe any of the following may report that information to any agency, as defined in s. 111.32(6)(a), of the state. . . :
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> 1. That the health care facility or health care provider or any employee of the health care facility or health care provider has violated any state law or rule or federal law or regulation.
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> 2. That there exists any situation in which the quality of any health care service provided by the health care facility or health care provider or by any employee of the health care facility or health care provider violates any standard established by any state law or rule or federal law or regulation or any clinical or ethical standard established by a professionally recognized accrediting or standard-setting body and poses a potential risk to public health or safety.

establish probable cause is a lesser one than in a case on the merits and has been described as "low," *Boldt v. LIRC*, 173 Wis. 2d 469, 496 N.W.2d 676 (Ct. App. 1992). The level of proof needed to establish probable cause is "somewhere between preponderance and suspicion." *Hintz v. Flambeau Medical Center,* ERD Case No. 8710429 (LIRC Aug. 9, 1989).

To establish a *prima facie* case of retaliation, a complainant must prove that (1) she engaged in statutorily protected conduct, (2) the respondent took an adverse action against her, and (3) a causal connection exists between the protected conduct and the adverse action. *Acharya v. Carroll*, 152 Wis. 2d 330, 448 N.W.2d 275 (Ct. App. 1989). For purposes of making out a *prima facie* case, the "causal connection" element can be established by showing that the adverse employment action followed within a fairly short period of time after the protected activity. *Notaro v. Kotecki & Radtke, S.C.*, ERD Case No. 8902346 (LIRC July 14, 1993), citing *Frierson v. ASHEA Industrial Systems*, ERD Case No. 8752356 (LIRC April 6, 1990). If a *prima facie* case has been established, the burden then shifts to the respondent to articulate a legitimate, nondiscriminatory reason for its actions. *Monroe v. Birds Eye Foods Inc.*, ERD Case No. CR200304303 (LIRC March 31, 2010). If the respondent carries its burden of production, the complainant then must show that the respondent's asserted reason was in fact a pretext for retaliatory conduct. *Id.*

The complainant met her burden of establishing a *prima facie* case of retaliation by showing that she made a report to a state agency regarding conduct described in § 146.997(2) of the HCWPA, and that she was discharged from her employment a week later. The burden then shifted to the respondent to articulate a legitimate, nondiscriminatory explanation for its actions. At the hearing the respondent stated that it discharged the complainant because of her history of misconduct. The

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Wis. Stat. § 146.997(2)

> (3) DISCIPLINARY ACTION PROHIBITED. (a) No health care facility or health care provider and no employee of a health care facility or health care provider may take disciplinary action against, or threaten to take disciplinary action against, any person because the person reported in good faith any information under sub. (2)(a), . . .

Wis. Stat. § 146.997(3)(a).

For purposes of the HCWPA, a "Health care facility" is defined, as follows:

> (c) . . . a facility, as defined in s. 647.01(4), or any hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health complex or other place licensed or approved by the department of health services under s. 49.70, 49.71, 49.72, 50.03, 50.35, 51.08 or 51.09 or a facility under s. 45.50, 51.05, 51.06, 233.40, 233.41, 233.42 or 252.10.

Wis. Stat. § 146.997(1)(c).

respondent further maintained that it did not know the complainant had engaged in statutorily protected conduct, since the DHS investigators refused to tell it who had filed the complaint against it.

The commission does not find the respondent's assertions credible. To begin with, the commission is not convinced that the respondent was unaware of the complainant's protected conduct. The complainant had complained to Ms. Bain about various conduct by other caregivers that she considered to be inappropriate and/or in violation of residents' rights. The complainant told Ms. Bain that if DHS heard what was happening at the respondent's facility it would probably shut it down. Shortly after that conversation an anonymous complaint was filed with DHS, which caused DHS to perform an unannounced investigation of the respondent's facility a few months later. Although Ms. Bain testified that DHS would not tell her who had filed the complaint, this does not mean that Ms. Bain did not *guess* it was the complainant. Moreover, the commission notes that at the hearing Ms. Bain testified that co-workers did not want to work with the complainant and stated that the number of reprimands the complainant received was not typical. She also indicated that the complainant did not want to perform cleaning tasks and suggested that other employees enjoyed cleaning and appreciated the variety. The tenor of Ms. Bain's testimony was that other workers got on better in the workplace than the complainant did and that the complainant was the only disgruntled employee. Given that, and in light of the complainant's earlier statement, it stands to reason that Ms. Bain would have assumed that it was the complainant who contacted DHS. Ms. Bain was not asked who she believed had filed the complaint, and her testimony centered on what she was told by DHS. The fact that Ms. Bain did not receive affirmative verification of the complainant's identity as the complaint filer does not mean that she had not figured out that the complainant was the person who filed the complaint or did not believe this was probably the case.

Further, at the hearing the respondent did not present a compelling reason for discharging the complainant. The complainant received a final disciplinary warning on October 30, 2014, and, without having engaged in any additional misconduct, was discharged on November 12. The only intervening event shown to have occurred between the final warning and the date of discharge was the visit from DHS to the respondent on November 5 and 6. (While a note attached to the complainant's discharge notice indicates that on November 10 the laundry room door was left propped open, in violation of state codes, no further evidence regarding this incident was presented and Ms. Bain did not reference it as a reason for the discharge.) In her decision finding no probable cause, the administrative law judge found that the complainant was discharged because she continued to make medication errors and because other employees did not want to work with her. However, the respondent had already dealt with the medication errors by taking that duty away from the complainant, and with the exception of a comment

included in the discharge paperwork, it presented no evidence establishing that it received complaints from the complainant's co-workers subsequent to the final warning that made it change its mind about continuing to employ the complainant.

Absent any clear and convincing explanation from the respondent as to why it decided it needed to discharge the complainant only two weeks after it concluded that discharge was not necessary as long as the complainant was taken off of the job of dispensing medications, and a week after the unannounced investigation by DHS, the commission finds that there is a reasonable ground for belief that discrimination probably occurred. The complainant is therefore entitled to a hearing on the merits of her complaint.

NOTE: The parties should be advised that the hearing on the merits is an entirely new hearing which does not incorporate the testimony or exhibits presented at the probable cause hearing, nor will the administrative law judge be bound by the findings made in this decision.