

**UNITED STATES OF AMERICA  
BEFORE THE NATIONAL LABOR RELATIONS BOARD**

1621 ROUTE 22 WEST OPERATING  
COMPANY, LLC D/B/A/ SOMERSET  
VALLEY REHABILITATION AND  
NURSING CENTER

and

1199 SEIU UNITED HEALTHCARE  
WORKERS EAST, NEW JERSEY REGION

Cases 22-CA-29599  
22-CA-29628  
22-CA-29868

**CHARGING PARTY'S ANSWERING BRIEF TO RESPONDENT'S  
EXCEPTIONS TO THE DECISION OF THE ADMINISTRATIVE LAW JUDGE**

GLADSTEIN, REIF & MEGINNISS, LLP  
817 Broadway, 6<sup>th</sup> Floor  
New York, New York 10003  
Phone: (212) 228-7727

Attorneys for SEIU 1199 United Healthcare  
Workers East

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## **PRELIMINARY STATEMENT**

On November 21, 2011, after a nineteen day hearing, Administrative Law Judge Steven Davis issued a decision finding that Respondent, 1621 Route 22 West Operating Company, LLC d/b/a Somerset Valley Rehabilitation and Nursing Center, (“Somerset” or the “Facility”) violated Sections 8(a)(1) and (3) of the Act by disciplining and ultimately terminating employees who were leaders of the effort to obtain union representation, reducing and eliminating all hours of work for certain per diem employees and by interrogating employees and soliciting employee grievances. Respondent filed 106 exceptions to the findings of the ALJ, including his factual, legal and credibility findings. Contrary to the claims of Respondent, the ALJ’s findings are amply supported by the record evidence and well-established legal authority.

## **SUMMARY OF ARGUMENT**

Respondent argues that the ALJ failed to adequately consider that the disciplinary actions it took against the discriminatees after the NLRB election resulted from a new management team’s efforts to transform Somerset, and not in retaliation for the employees’ union activity. Respondent states that it was purely coincidental that the placement of the new administrator and director of nursing by the parent company, Care One, coincided with the Union election. The ALJ fully considered this defense and rejected it. His rejection is fully supported by the record, which is replete with evidence contradicting Respondent’s claim.

Days after receiving the representation petition filed by 1199 SEIU, United Health Care Workers East (the “Union”), Care One replaced an unpopular administrator at Somerset with a new administrator, who attempted to curry favor with employees during Respondent’s intensive and aggressive anti-union campaign. Significantly, Respondent concedes that it disciplined the employees for conduct that was tolerated in the past. It claims, however, that it needed to

transform the facility after receiving poor results from the annual inspection survey conducted by the New Jersey Department of Health and Senior Services (“DHSS”) in December 2009 and to prevent future unacceptable surveys. This defense falls flat because Respondent waited eight months before replacing the administrator and director of nursing, even though the next annual inspection could have taken place as early as August 2010—the month the administrator was replaced and a new director of nursing (“DON”) was installed. Further, the unrebutted testimony of Respondent’s former supervisor, Jacqueline Southgate, provides direct and corroborative evidence that Respondent terminated the three employee leaders, Shannon Napolitano, Sheena Claudio and Jillian Jacques, because of their Union activity.<sup>1</sup>

## ARGUMENT

### **I. THE ALJ PROPERLY REJECTED RESPONDENT’S DEFENSE THAT THE UNION LEADERS WERE FIRED BECAUSE NEW MANAGEMENT IMPOSED HIGHER STANDARDS, AND NOT BECAUSE OF EMPLOYEE UNION ACTIVITY.**

Respondent argues that this case arises out of business decisions underlying its desire to improve operational and clinical performance in response to receiving an unsatisfactory State survey inspection in November and December 2009, and that the new management placed at Somerset Valley in August 2010 disciplined the discriminatees because it held employees to higher standards.<sup>2</sup> The ALJ correctly rejected this defense and found that Respondent

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<sup>1</sup> Charging party submits that Valerie Wells was also discharged for her support of the Union and that the hours of the per diem employees were eliminated because of their Union support. The facts surrounding these violations are fully discussed in the brief of the General Counsel and are not addressed here.

<sup>2</sup> The State survey results were issued on December 10, 2009, but the survey took place in November 2009 and Jason Hutchins, Regional Director of Operations for Care One, was aware that Somerset was to be cited for “G” level deficiencies during the survey process. (R-33; Tr. 1435.)

“Tr.” refers to the transcript of the hearing before the ALJ; “GC” refers to the General Counsel’s exhibits; “R” refers to Respondent’s exhibits; and, “CP” refers to Charging Party’s exhibits.

disciplined and ultimately discharged the discriminatees beginning a few weeks after the election in September 2010 because of their union activity.

**A. Placement of new management almost immediately after the filing of the representation petition**

Somerset Valley is a Care One skilled nursing facility, closely monitored and controlled by Care One. Jason Hutchins, Regional Director of Operations for Care One, whose jurisdiction covered Somerset Valley, testified that the Center administrator reported to him.

Respondent's contention that Administrator Elizabeth Heedles' removal approximately one week after receiving the Union's petition was merely coincidental is not credible. Hutchens testified at length about the severity of the 2009 State survey results, the challenge to the future of the Center, his vexing concerns about Administrator Heedles' performance as a result of the 2009 State survey and Care One's strong view that it could not have a repeat of a bad survey in 2010.<sup>3</sup> However, the record reveals that Respondent did not act to replace Heedles until late July 2010, days after the July 22<sup>nd</sup> representation petition was served. Not only was this eight months after the poor survey, it was possibly only one month prior to the next annual survey that could have taken place as early as August 2010.<sup>4</sup>

On August 3, 2010, Care One abruptly removed Somerset Valley administrator, Elizabeth Heedles.<sup>5</sup> Heedles was extremely unpopular with employees, and had announced radical

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<sup>3</sup> Respondent's Brief in Support of its Exceptions to the Administrative Law Judge's Decision is referred to as "Resp. Br."

<sup>4</sup> The annual State surveys are unannounced and take place anywhere from nine to fifteen months after the prior year's survey. (Tr. 1423.) Konjoh testified that when she arrived at Somerset, she was told by Hutchens and Illis that the survey window was open and there was going to be a survey at any time. (Tr. 2009.)

<sup>5</sup> Respondent argues that the ALJ erred by stating that Respondent did not take affirmative steps relating to changes in its administration at Somerset Valley or increased oversight following the

scheduling changes that were so upsetting to employees that they lodged complaints with the Care One corporate office several months prior to the filing of the petition. (Tr. 1513.) After ignoring these employee complaints for months, Care One removed Heedles and halted her plans to implement the unpopular schedule changes that were to go into effect on August 1, 2010.

Despite the long period of purported dissatisfaction with Heedles, Respondent's replacement of her with the new administrator, Doreen Illis, could not have been more abrupt. Illis was offered the Somerset Valley position on Friday night, July 30<sup>th</sup>. On the following Sunday night, she received a call from Care One President Folio, decided to accept the job the next day and began work the following day, Tuesday, August 3<sup>rd</sup>. (Tr. 2672-73.) Her superior, Jason Hutchens, did not know her before she was hired and he did not interview her, as was his custom. (Tr. 1640, 3065.) Illis testified that this was a sudden transition. (Tr. 3067.)

Similarly, the new DON, Inez Konjoh, quickly replaced the prior DON shortly after the filing of the petition.<sup>6</sup> Konjoh was the assistant DON at another Care One facility and her placement at Somerset was so sudden that Care One did not await the return of its Vice-President of Clinical Operations for Care One, Jackie Engram, from her vacation the first two weeks of August. (Tr. 1920-21.) Engram testified that she was the person who had the best knowledge of the performance of the DONs at the various Care One facilities and that, before she left for vacation, the DON position at Somerset was not vacant. (Tr. 1920-24.)

One can only conclude that the rush to remove Heedles and install Illis within days after Care One learned of the filing of the petition was in response to the petition, and not in response to clinical shortcomings highlighted by the 2009 State survey eight months earlier. Moreover, its

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2009 survey. (Exception 11, Resp. Br. at 53.) The ALJ's finding is correct: the administrator and the DON were not replaced until eight months after the survey.

<sup>6</sup> The prior DON was asked to resign. (Tr. 1925.)

claim that new management brought significant improvement to clinical areas was not supported by the record. The Facility received numerous deficiencies in the DHSS survey in December 2010; Hutchens testified that the State cited “a lot of deficiencies” and Illis described results as “terrible.” (Tr. 1479, 3112.)

Indeed, Respondent’s new DON Konjoh was ineffective and was removed from her position after only five months. According to Engram, as early as November (less than three months after she was hired), Konjoh’s performance deficiencies were apparent and she was removed from her position as DON because her performance relating to clinical matters, including timely investigations of incidents and accidents, was unsatisfactory. (Tr. 1958-60.)<sup>7</sup>

**B. The ALJ properly rejected Respondent’s claim that increased scrutiny was due to new management.**

Respondent claims that Illis and Konjoh arrived to find significant operational and clinical shortcomings. It claims they found no systems in place, that no audits of records and procedures were being conducted and that Konjoh found that nursing protocols and policies were not being enforced. (Resp. Br. at 21-22.) The ALJ found that given the strict oversight of the facility by Care One, it was inconceivable that such shortcomings were not known prior the employees’ interest in unionization. ALJD at 16-17.

The record reveals that Care One maintained regular oversight of its nursing home facilities. Hutchins testified that he visited Somerset at least one full day a week and that each of the five Care One regional staff would also visit at least weekly. He further testified that the Care One regional nurse visited the facility more than once a week to maintain compliance with nursing policies, write performance improvement plans and monitor performance on a regular basis “weekend (sic) and week out.” (Tr. 1403, 1410, 1607-10, 1616-17.) Employees were

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<sup>7</sup> Konjoh was the assistant DON at Care One’s East Brunswick facility when the Union was unsuccessful in its efforts to organize employees at that facility in 2009. (Tr. 2315-16.)

subject to Care One terms of employment and were required to follow its policies and Code of Conduct. (R-40, Tr. 1488.) Thus, the record supports the ALJ's rejection of the claim that prior to the arrival of Illis and Konjoh, Respondent had no systems in place, did not conduct audits and did not enforce nursing policies.

**C. Respondent's hostility toward employee unionization efforts**

Respondent claims that Illis and Konjoh were installed at the Center to immediately improve its clinical operation, especially in view of the impending annual State survey. To the contrary, the record reveals that upon their arrival, resources were diverted to an intensive anti-union campaign launched by Illis and Care One where employees were pulled away from their assignments to attend round-the-clock mandatory meetings and bombarded relentlessly with Respondent's campaign materials.

Lynette Tyler testified that during Illis's first week at Somerset Valley, Illis went to employees and asked them what problems led them to want a union. (Tr. 117-18.)<sup>8</sup> This testimony is corroborated by the August 10<sup>th</sup> notice Illis sent to employees in which she noted that "many" employees had expressed their opposition to the Union and that their "support was appreciated," as well as her testimony that she spoke to many employees before sending this August 10<sup>th</sup> notice. (CP-6, Tr. 3077-78.) It is also corroborated by the immediate reversal of Heedles' plan to implement unpopular schedule changes.

During the four week period between Illis' arrival and the NLRB election on September 2<sup>nd</sup>, Respondent's managers met almost daily with their labor consultant to assess Union sympathies of the potential voters on the Excelsior List and to assign supervisors to talk to particular employees. (Tr. 1518-20; 1569; 1655-56.) It also required employees to attend

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<sup>8</sup> Although Care One Regional Human Resources Director Andrea Lee was made aware of employee dissatisfaction with Heedles, no action was taken until the petition was filed.

numerous anti-union meetings where Respondent communicated its hostility toward unionization through power point presentations, videos and dozens of handouts distributed during a three to four week period. (Tr. 333-36; GC-12, GC-41, GC-24; CP-6, CP-12.) Illis' and Hutchens' descriptions of these meetings as "informational" and "educational" were disingenuous. (Tr. 1644, 3074, 3090.)<sup>9</sup> The materials included a video entitled *Unions on the Prowl*, and all of the flyers distributed to employees disparaged the motives of the Union and urged employees to vote no. (GC-41, GC-42, CP-6.) Two days before the election, Illis sent a letter to the eligible voters stating that she was committed to addressing employee issues "but only if the voters in our election give us the opportunity to work together without a union." (GC-12.) This evidence not only contradicts Illis's and Hutchens' characterization of the materials and undermines their credibility, it also reveals the extent of Respondent's hostility toward unionization.

Respondent's hostility toward unionization continued after the election. Illis testified that after the election, she told employees that she was disappointed with the election results and may have said she felt betrayed. (Tr. 3106.) Konjoh told Southgate that Respondent was looking closely at the work of the leading Union supporters to find a reason to write them up. (Tr. 1117-1118.) She proceeded to do just that.

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<sup>9</sup> Both Illis and Hutchens suffered from significant memory lapses when it came to the content of the flyers and materials presented at the employee meetings. Hutchens testified that employees were shown a 20-30 minute video about organizing, which showed employees discussing the idea of unionizing, and that the point of the video was not to show the negative aspects of unionization. (Tr. 1643.) Illis testified that the videos shown were not necessarily unfavorable to the Union. (Tr. 3092.) The testimony of these witnesses is flatly contradicted by the videos in evidence. (CP-12.) Illis further testified that Respondent did not tell employees to vote against the Union even though its numerous leaflets and other communications told employees, in no uncertain terms, to "vote no." (Tr. 3092-94; GC-41, GC-42, GC-12; CP-6, CP-12.)

## II. RESPONDENT DISCIPLINED NAPOLITANO, CLAUDIO AND JACQUES IN RETALIATION FOR THEIR UNION ACTIVITY.

The record evidence establishes that the discriminatees were engaged in protected activity, and that Respondent had knowledge of such activity and exhibited animus and hostility toward the organizing effort. *See Wright Line*, 251 NLRB 1083, 1089 (1980), *enfd.* 662 F.2d 899 (1st Cir. 1981); *Manno Electric*, 321 NLRB 278, 281 (1996). Employer knowledge of protected activity and anti-union motivation in taking adverse action against a specific employee may be proven by circumstantial as well as direct evidence. *See, e.g., Dlubak Corp.*, 307 NLRB 1138, 1155 (1992), *enfd.* 5 F.3d 1488 (3d Cir. 1993); *Abbey's Transportation Services*, 284 NLRB 698, 700, 701 (1987), *enfd.* 837 F.2d 575 (2d Cir. 1988). The timing of the employer's adverse action is especially strong evidence that anti-union animus was a motivating factor. *Sears, Roebuck & Co.*, 337 NLRB 443 (2002); *American Cyanamid Co.*, 301 NLRB 253 (1991).<sup>10</sup>

### A. Employer knowledge of the discriminatees' Union activities and support

Respondent claims that the employees' Union activity simply coincided with its business decision to improve its operations and that the General Counsel failed to offer evidence of unlawful motivation beyond coincidental timing. It also challenges the ALJ's findings that the Union activities of Napolitano, Claudio and Jacques were well known to Respondent, stating that Illis and Konjoh were unaware of any Union activity of Napolitano and Jacques other than that they served as Union election observers and did not know whether Claudio was a Union supporter. Exceptions 63, 64; Resp. Br. at 26 fn. 41.

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<sup>10</sup> Respondent argues that "logic dictates" that if it had been motivated by the Union's organizing drive rather than its business concerns, it would have terminated the discriminatees prior to the election. Resp. Br. at 70 fn. 98. That "logic" has never been accepted by the Board, which has found unlawful discharges in *response* to union election victories. *See, e.g., St. John's Community Services—New Jersey*, 355 NLRB No. 70 (2010).

Aside from the extremely *coincidental* timing of Respondent's close monitoring of the discriminatees and unprecedented discipline for previously tolerated conduct, the General Counsel presented compelling and direct evidence through the testimony of Unit Manager Southgate that Respondent was targeting the employee leaders of the Union organizational effort. Southgate testified that she attended management meetings held several times a week in August, led by a consultant where the attendees went through the Excelsior List to identify Union supporters. (Tr. 942-5, 947-50.) Napolitano, Claudio and Jacques were identified as strong Union supporters. (Tr. 947-50.) Also discussed at these meetings were a flyer and a YouTube video distributed by the Union in August in which employees, including Napolitano, Claudio and Jacques, gave testimonials as to their reasons for supporting the Union. (Tr. 950-51; GC-10, GC-11.)<sup>11</sup>

**B. Respondent's retaliation for Union activity**

The record in this case establishes through both direct and circumstantial evidence that the disciplines and discharges of Napolitano, Claudio and Jacques were in retaliation for their Union activity and that Respondent cannot meet its burden of demonstrating that the action would have taken place in the absence of the employees' protected activities. To meet its burden, Respondent "cannot simply present a legitimate reason" for its conduct, but must "persuade by a preponderance of the evidence" that it would have taken the action in question in the absence of the protected activity. *Hospital San Pablo*, 327 NLRB 300, 308 (1998), *enfd.* 207 F.3d 67 (1st Cir. 2000) (*citing T&J Trucking Co.*, 316 NLRB 771 (1995)). The Respondent here has fallen short of meeting its burden.

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<sup>11</sup> Respondent misrepresents the record, stating "it was undisputed that Hutchens did not tell Illis about the YouTube video." To the contrary, Hutchens affirmatively testified that he told Illis about the YouTube video soon after viewing it. Exception 63. (Tr. 1523-24.)

While in many retaliatory discharge cases, proof of unlawful motive is circumstantial, here there is both compelling circumstantial and direct evidence of motive. It is undisputed that after the election, management began to closely monitor the work of these employees. Southgate, a supervisor on the day shift, observed that Konjoh reviewed the medication administration records (the “MARs”) for Napolitano and Claudio more closely than for others. (Tr. 914-15.)<sup>12</sup> She testified that after the Union election, Konjoh met with her and told her that she expected her to write employees up, that they would be looking closely at the people they thought were Union organizers and that if they were given a reason to write them up, they would do so.<sup>13</sup> (Tr. 934-35, 1117-18.) Not only was Southgate a credible witness, her testimony was substantiated by other evidence in the record including disparate treatment and conduct by Konjoh and Illis who compromised resident care in imposing discipline.

Respondent challenges the ALJ’s finding that Southgate’s testimony was credible by grasping for straws. It argues that Southgate should be discredited because she testified that she “could not recall exactly,” citing to testimony on page 1118 of the hearing transcript. Exception 21, Resp. Br. at 56. A review of Southgate’s testimony reveals that it was straightforward and that she was careful to answer questions and qualify details where she could not precisely recall all of them. She withstood lengthy questioning on cross-examination, which the ALJ noted during her cross-examination was “excruciatingly detailed.” (Tr. 1112.) Although Southgate felt her discharge by Respondent was unfair, she expressed no hostility or animosity toward Respondent.

Southgate’s credibility is supported by the facts. Her testimony that Respondent was looking for reasons to discipline employees was supported by Respondent’s actions beginning

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<sup>12</sup> Jacques did not work the same shift as Southgate.

<sup>13</sup> See GC-46.

less than two weeks after the election, when Respondent issued two separate warning notices to Claudio and Jacques and a warning notice to Napolitano for tardiness and absences going back to January 2010. Respondent did not call Heedles or any other former Somerset Valley manager to dispute the testimony of employees that these alleged attendance infractions were either authorized or condoned in the past. Within three weeks, Napolitano and Claudio were fired and Jacques, an eleven year employee, was disciplined and ultimately discharged several months later. Southgate's testimony, together with the timing of the disciplines, disparate imposition of discipline on Union supporters and pretextual reasons for discipline, firmly establish that the employees' protected activity was a motivating factor in Respondent's decision to take adverse action.

### **C. Disciplines for time and attendance**

Although Respondent excepted to the ALJ's finding that prior to the election, employees were not generally disciplined for lateness and absenteeism, it points to no record evidence disputing that to have been the practice. (Exception 6.) Indeed, Respondent states that absenteeism and tardiness was "rampant among employees upon Illis's and Konjoh's arrival at the Center." (Resp. Br. at 19.) The retaliatory nature of these disciplines is established by the following: (1) the conduct was tolerated or condoned for a long period of time; (2) even though Illis observed these problems upon her arrival, she never informed employees during the numerous meetings held with them prior to the election that the lax time and attendance practice must cease; (3) the disciplines were issued after the election and more than a month after Illis determined that absenteeism and tardiness were rampant; and (4) disparate treatment as evidenced, for example, by the fact that employee Agu was not disciplined even though she was late 34 times out of the 37 shifts she worked between July and late September 2010.

(ALJD at 15.)<sup>14</sup> In addition, Respondent did not follow progressive discipline; rather than giving employees verbal warnings, it issued written ones and issued Claudio and Jacques two separate warnings on September 13, 2010, designated 1<sup>st</sup> written and 2<sup>nd</sup> written warning, for these time and attendance infractions. (GC-14, GC-15, GC-31, GC-40.) Finally, one of the warnings received by both Claudio and Jacques was issued for taking sick leave before or after a day off even though, as found by the ALJ, the employee handbook contained no such prohibition.<sup>15</sup>

**D. Discipline and discharges of the LPN leaders of the Union organizing campaign**

Shannon Napolitano, Sheena Claudio and Jillian Jacques were licensed practical nurses responsible for caring for nursing home patients. Aside from an instance when Napolitano dispensed mineral zinc to a resident after it had been discontinued<sup>16</sup> and Claudio dispensed a baby aspirin for one day, all of the disciplines related to inadequate or incomplete documentation. No resident was harmed in any way by the infractions for which these nurses were disciplined. Indeed, across the nursing home industry, nursing errors are common; in New Jersey alone, 91% of the nursing homes were cited for deficiencies in 2007.<sup>17</sup> While in a perfect

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<sup>14</sup> That other employees who were not known Union supporters also received disciplines does not provide cover for Respondent. *See, e.g., Bay Corrugated Container, Inc.*, 310 NLRB 450 (1993) (“The Board has held that, in the context of a union organizing drive, the discharge of a neutral employee in order to facilitate or cover up discriminatory conduct against a known union supporter is violative of Section 8(a)(3) and (1).”).

<sup>15</sup> Respondent argues that these disciplines were effective, citing the improved attendance of Jacques and Napolitano. However, Napolitano was discharged four days after receiving these warnings.

<sup>16</sup> Napolitano was also disciplined for not watching the resident who was given the discontinued zinc pill swallow the pill.

<sup>17</sup> According to a memorandum of the Inspector General for the U.S. Department of Health and Human Services issued September 2008, 91% of nursing homes surveyed were cited for deficiencies in 2007. (CP-3.) The most common deficiencies cited were for quality of care, resident assessment and quality of life. (*Id.*) Hutchens testified that the average number of deficiencies found in New Jersey nursing homes in 2011 was even higher than the number found in the 2008 report. (Tr. 1689-90.)

world no medical errors would occur, they unfortunately are common given the nature of the industry. The records of numerous in-service educational sessions and nurses meetings where incomplete documentation was repeatedly addressed reflect that documentation omissions were a continuing and pervasive issue at Somerset. (CP-1, CP-2, CP-4, CP-5, R-1, R-3, R-7, R-8.)

**1. Shannon Napolitano**

Respondent quickly terminated Napolitano's employment on September 17<sup>th</sup> by seizing an opportunity to essentially frame her. As found by the ALJ, the circumstances surrounding the events for which she was discharged put into question Respondent's motivation. On September 16<sup>th</sup>, Konjoh was informed that a patient complained that none of the nurses except Napolitano was giving her a pink pill. Konjoh checked the MAR and saw that no pink pill was prescribed. She then went to the patient and told her that if the nurse gave her the pill, not to take it; however, Konjoh took no action to prevent the pill from being dispensed to the patient again. (Tr. 2563-69.) Given that the patient told Konjoh that she always got the pill (Tr. 2567) and Konjoh had every reason to believe the pill would be given to the patient the next day, the only plausible explanation for Konjoh's irresponsible conduct was to trap Napolitano. Konjoh testified that she did not know what the pink pill was at the time she spoke with the patient and that it could have been a more potent medication than what was later determined to be zinc. (Tr. 2569.) Konjoh admittedly did nothing to prevent Napolitano from giving the patient the pink pill again: she did not remove the pink pill from the medication cart, nor did she attempt to speak to Napolitano on the 16<sup>th</sup> or at any time prior to the 9:00 a.m. medication pass the following day, even though Napolitano arrived at work at 6:45 a.m. (Tr. 2567-68.) That Konjoh was looking to find a reason to discharge Napolitano was further substantiated by Southgate, who testified that Konjoh told her that she had instructed the patient to hold the pill. (Tr. 963-64) Napolitano gave

the pill to the patient and was discharged that day. Respondent was so intent on discharging Napolitano that it risked permitting a patient to be given an unprescribed medication of unknown potency.<sup>18</sup>

Strangely, the termination notice also criticized Napolitano for failing to observe the patient take the zinc pill. Konjoh was asked, “You are referring to the pill the patient should not have taken, correct? A: Yes.” (Tr. 2569-70.) Presumably, had the patient actually swallowed the pill, Napolitano would not have been written up for that additional infraction.<sup>19</sup> Remarkably, Respondent excepts to the ALJ’s mild statement that it seemed that Konjoh was overreaching in disciplining Napolitano for failing to ensure that the patient swallowed the discontinued medication. (Exception 32.)

The ALJ found that Napolitano administered the zinc after it had been discontinued but noted that other nurses who did so were not disciplined. Respondent’s explanation that it did not discipline the two other nurses who documented having given the medication because they denied giving it is hardly credible in view of Konjoh’s testimony that she did not believe the nurses, and that their initials on the MAR were not crossed out. (Tr. 2381-82.)<sup>20</sup>

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<sup>18</sup> In Exception 31, Respondent excepts to the ALJ’s finding that Konjoh “took no steps to remove the medication from the cart or advise Napolitano of the fact.” In fact, Konjoh testified that she did not take the medication off the medication cart and that she did not speak to or attempt to speak to Napolitano prior to the next medication pass to prevent her from giving the patient the pill. (Tr. 2167, 2567-68.)

<sup>19</sup> In Exception 27, Respondent misstates the ALJ’s finding. The Exception states that the ALJ found that “Napolitano waited until [the patient] swallowed all the medications.” In fact, the ALJ’s decision states that “Napolitano *testified* that she did not recall whether she gave the patient a pink pill but waited until she swallowed all the medications she gave her.” (ALJD at 19 (emphasis added).) Exception 33 similarly misstates the ALJ’s findings by omitting that the ALJ stated that “*Southgate confided to Claudio*” that Napolitano had been set up. (ALJD at 21 (emphasis added).)

<sup>20</sup> Unlike Claudio, who actually scratched out her initials, these nurses did not. Konjoh’s explanation that, “I didn’t believe it but I had to go by what the employees had to say” is hardly credible given that she disciplined the discriminatees for alleged infractions that they categorically denied.

The final infraction for which Napolitano was terminated, the oxygen saturation documentation, was such an obvious transcription error that it would have readily been recognized as such by anyone viewing the record and would have been corrected by Napolitano before the end of her shift. Corroborating General Counsel's witnesses, Engram testified that nurses may review their charting at the end of their shifts to correct any errors or add missing information. (Tr. 1982-83.) Because Napolitano was terminated mid-way through her shift, she did not have the opportunity to review her charting as she typically did at the end of her shift and correct this documentation error. (Tr. 369.)

Napolitano's termination essentially boils down to having given a resident the mineral zinc after it had been discontinued.<sup>21</sup> Her error did not result in any harm to the resident and would have been avoided if several safeguards had been in effect.<sup>22</sup> Prior to September 17, 2010, Napolitano had received no prior disciplines for medication errors.<sup>23</sup> As detailed further

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(Tr. 2381-82.) For example, Claudio insisted she had completed an admission note, but was nevertheless disciplined for allegedly not doing so on September 27, 2010.

Contrary to Respondent's claim, the discontinuation of the zinc on the MAR was not clearly delineated. Medications that are discontinued are more clearly marked as "D/C." (R-82.)

<sup>21</sup> In Exception 28, Respondent misrepresents the ALJ's finding, when it states that the ALJ found that Napolitano administered the zinc pill "*only*" on August 25<sup>th</sup> and 30<sup>th</sup> (emphasis added). The ALJ did not state "only" and, when he referred to August 25<sup>th</sup> and 30<sup>th</sup>, he was referencing the August MAR which reflects Napolitano's initials on those two days. (R-82.)

<sup>22</sup> The 24 hour chart check discussed below would have caught these errors. The 24 hour chart check is performed every night by night shift nurses who review the medication and treatment records of the nurses on the prior shifts to ensure that medications and treatments are dispensed in accordance with physician orders. The MAR did not contain the customary "D/C" for zinc, representing discontinuation. Nor was the medication taken out of the med cart when it was discontinued. While these omissions do not excuse Napolitano's error, they are mitigating factors.

<sup>23</sup> The only prior discipline Napolitano received was a written final warning on January 4, 2010 relating to the documentation of pain assessments. Respondent repeatedly faulted the ALJ for failing to acknowledge its adherence to a policy of progressive discipline. (Exception 39.) According to Respondent's Code of Conduct, disciplines are implemented as follows: documented verbal warning, written warning, written reprimand, then suspension and finally termination. (R-40.) There is no step of "final warning." Moreover, the use of final warnings in the progressive disciplinary scheme is both

below, the Employer treated Napolitano disparately by discharging her for the type of errors alleged on September 17<sup>th</sup> and doing so after only one written, albeit final, warning.<sup>24</sup>

## **2. Disciplines and discharge of Claudio**

The same day Napolitano was discharged, a final written warning was issued to Claudio for having given a patient baby aspirin two days in a row on September 8<sup>th</sup> and 9<sup>th</sup>, when she should have given it on only one day. As Claudio's first medication error, this final written warning for giving a baby aspirin on one occasion is not consistent with Respondent's purported progressive discipline policy.

The ALJ noted that the nurse who entered the medication order for baby aspirin on the MAR did not block off the days the medication was not to be administered, as is the practice at Somerset.<sup>25</sup> ALJD at 22. (Tr. 139, 612-13.) Another nurse, Doreen Dande, had made the same error days prior to Claudio but was not written up until after Claudio made the error days later. Although the error should have been picked up by the nurses performing the nightly 24 hour chart check on the 11 p.m. to 7 a.m. shift, Respondent introduced no evidence that any nurse on the 11-7 shift was disciplined for failing to catch this charting error for several days in a row. There was no evidence that the patient was harmed by this error.

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inconsistent and not necessarily followed by more severe discipline or discharge, as in Napolitano's case. For example, nurse Doreen Dande received a final written warning followed by a written warning, further followed by a first written and second written warning. (R-85, R-93, R-98, R-83.) Claudio was not discharged but was suspended after receiving a written final warning. (GC-19; R-860.)

<sup>24</sup> Respondent notes that it follows two disciplinary tracks—one for attendance and another for performance—such that an attendance discipline is not counted against an employee for performance disciplines. (Tr. 2085.)

<sup>25</sup> Respondent does not dispute that it was the practice at Somerset to block off days that a medication is not to be given to minimize medication errors.

Respondent argues that it did not discipline the nurses responsible for the 24 hour chart check because Konjoh was not aware of any such requirement. (Resp. Br. at 27 fn. 43.) Engram, the Vice-President of Clinical Operations for Care One, testified that the 24 hour chart check was required to ensure medications were correctly documented and that the nurse who did not catch the error on the 11-7 shift should be disciplined. (Tr. 1975-77.) Moreover, the 2010 DHSS Plan of Correction in response to a state survey required that this chart review of MARs and TARs (treatment administration records) be performed daily on the 11-7 shift. (CP-1 at p. 4.) It is not credible that Konjoh, as the Director of Nursing, who had previously been an assistant director of nursing at another Care One facility, would not know of this Care One requirement or the Plan of Correction.<sup>26</sup>

Claudio was suspended days later on October 1<sup>st</sup> for four purported documentation infractions. Respondent's only exception to the ALJ's findings regarding this discipline was its claim that the ALJ failed to acknowledge that Claudio admitted all but one of these infractions. (Exception 34.) However, Claudio made no such admissions. Respondent does not dispute that Claudio firmly denied failing to do an admission note. (R-86 at Bates 3487.) Further, she also denied ever being confronted with the charge that she treated a skin tear without a physician's order.<sup>27</sup> (Tr. 184.) She admitted to failing to chart a post-fall for two days but noted that she performed neuro checks and monitored the patient. (GC-20; R-86.) As noted by the ALJ, other

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<sup>26</sup> Konjoh denied ever seeing the Plan of Correction. It is remarkable that a new DON would not review all plans of corrections. In any event, she should have known that the 24 hour chart check was required by Care One.

<sup>27</sup> The second page of R-86, which Claudio testified she had not seen, accused her of treating a patient before obtaining a physician's order for treatment and failing to write the physician's order after contacting the physician. This treatment was for a minor scratch; Claudio treated the cut, then contacted the physician and completed several pages of paper work. (R-86 at Bates 3492A-E.) The record is also unclear as to what order Claudio was to record, as the treatment she provided was minor first aid. (R-86 at Bates 3492A.)

nurses who committed similar infractions received far less discipline. In addition to employee Sandy Mootosamy,<sup>28</sup> who the ALJ noted committed similar misconduct and only received a written warning, other nurses were similarly treated far less severely than Claudio. Nurse Beck failed to complete admission charting on September 28<sup>th</sup> and was issued only a verbal notice. (R-90.) Nurse Santos was issued a verbal notice for incomplete admission assessment “in many areas” even though the notice states that Santos had been previously educated on this issue. (R-91.) Dacres failed to follow through on interventions for a patient who had a status change but was issued only a first written notice, and Dande was issued only a written notice for failing to notify the physician and patient family when a wound was found on a patient. (R-98 at Bates 00437; R-93.) In contrast, Claudio contacted the physician and there is no claim that her intervention was not appropriate.

Claudio was terminated on October 8<sup>th</sup>, ten days later, for attempting to document on the TAR treatments she had administered during her day shift when she returned to the facility at 11 p.m., seven or eight hours after her shift ended. Respondent excepts to the ALJ’s finding that in her testimony, Konjoh attempted to embellish the reasons for Claudio’s termination when she testified that Claudio had not actually done the treatments. (Exception 73.) The ALJ’s finding was amply supported by the record. First, the October 21, 2010 termination letter makes no mention of a failure to perform treatments; it only specifically references the failure to complete documentation. (GC- 25.) In apparent realization that termination was an excessive penalty for the failure to timely document treatments, Konjoh tried to claim that Claudio did not complete all

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<sup>28</sup> Mootosamy failed to document a fall on two occasions and to complete admission and other documentation. (R-92; Tr. 2257-58.)

of the treatments.<sup>29</sup> However, her testimony was shifting and not credible. She stated that the evidence that treatments were not administered by Claudio was Claudio's failure to sign the TAR. (Tr. 2558.) Despite her claim that she investigated whether the treatments were given and determined that they were not in fact given, Konjoh could not identify any treatment that was not performed. (Tr. 2559.) When confronted with the termination notice issued two weeks after Claudio was escorted from the facility on October 7<sup>th</sup>—which made no reference to any failure to perform a treatment but rather referred only to a failure to complete documentation—Konjoh conceded that the reason for termination was the documentation. (Tr. 2559; GC-25.) Finally, Respondent's position statement to the NLRB makes clear that the discharge was for documentation and not for any failure to administer a treatment. (GC-117.)<sup>30</sup>

Claudio testified that she had performed all of the treatments, recorded them on a paper she carries with her throughout her shift but forgot to document the treatments on the TAR at the end of her shift.<sup>31</sup> When she entered the facility, she told the shift supervisor Janet Matthias that she had forgotten to sign the treatments in the TAR and Matthias said okay. (Tr. 169.) Matthias was not called as a witness to dispute this testimony. Illis, however, viewed this procedure differently, told Claudio she could not initial the TAR and that it would be forgery and directed her to leave.

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<sup>29</sup> Respondent's exhibit 25 contains an unsigned draft of a disciplinary notice dated October 8<sup>th</sup>—two weeks before the date of the termination letter and prior to her investigation. It is not credible that Respondent would have omitted a failure to actually perform treatments if it had evidence of such failures. This document is inconsistent with the other record evidence.

<sup>30</sup> For these same reasons, Respondent's Exception 35 is without merit.

<sup>31</sup> Some nurses kept track of treatments on a piece of paper during the course of their shifts and entered them later in the shift. *See, e.g.*, Napolitano's testimony. (Tr. 369.)

The ALJ cited testimony establishing that nurses had completed documenting the TARs at the end of the shift or the day after. Southgate testified that nurses have completed TARs on the next day without being disciplined. (Tr. 967, 994, 1119-10.) This is consistent with Mathias' response of "okay" to Claudio's statement that she had returned to complete the TARs, and with Konjoh's testimony that nurses can enter late treatments on MARs if on the same shift or day that the treatment was given. (Tr. 2554-55.) It is also consistent with the practice as described by LPN Mangel, who testified that she observed Dande complete her TAR in October on a day following the date on which her treatments had been administered.

Significantly, as noted by the ALJ, the failure to complete MARs and TARs documentation was widespread and evidenced by the agendas from nursing meetings and in-services before and after Konjoh's arrival at Somerset, where it was repeatedly noted that there were blanks on the MARs and TARs. (Tr. 1172-73, CP-1, CP-2, CP-5, R-1, R-3, R-8, R-15.) Rather than permit Claudio to complete the TAR documentation so that the treatment records accurately reflected the treatments given, Illis chose to leave the records incomplete, notwithstanding that Respondent had been cited by DHHS in early 2010 for failing to maintain complete TARs and MARs. (CP-1.)<sup>32</sup>

Finally, Respondent argues that Illis and Konjoh were not aware whether Claudio was a Union supporter. As discussed below, that claim is not credible in view of Claudio's visible

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<sup>32</sup> In footnote 50 of Respondent's brief, Respondent mischaracterizes Claudio's testimony. Contrary to Respondent's claim, Claudio consistently testified that she generally completed her TARs at the end of her shift. (Tr. 210-14.) Respondent argues that Claudio testified she would document treatments "*after five patients*" when it is clear from her testimony that she used "five" as an example; *i.e.*, if she had five patients that day, she would chart all five of them when she sat down to do her notes. (Tr. 210-11 (emphasis in the original).)

support for the Union.<sup>33</sup> Accordingly, the record evidence fully supports the ALJ's findings that Claudio was treated disparately when she was terminated for failing to document treatments she gave on the MAR during her shift.<sup>34</sup>

### **3. Disciplines and discharge of Jacques**

Jacques was employed by Somerset Valley for eleven years before her discharge. At times, including during the period following the election when Respondent began to discipline her, she was assigned the trusted role of charge nurse. Respondent began disciplining Jacques on September 14<sup>th</sup> by issuing two separate warning notices relating to attendance, addressing conduct going back to January 2010. (GC-39, GC-40.) Respondent proceeded to issue two unjust disciplines to Jacques over the next several months and in early February, two weeks after the NLRB Hearing Officer issued a decision rejecting Respondent's election objections (and crediting the testimony of Jacques over Respondent's witness Konjoh), Respondent seized upon documentation errors to justify Jacques' discharge. Jacques was the last remaining employee leader of the unionization drive.

Southgate testified on cross-examination that Konjoh had a discussion with her about writing up employees in which she stated that if she was given an excuse, she would discipline Jacques but that Jacques was being very careful. (Tr. 1117-18.) Jacques was issued a first written warning on September 28<sup>th</sup> for allegedly failing to chart a post-fall for two days when, in

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<sup>33</sup> Even if Respondent had no knowledge of Claudio's support for the Union, its conduct would be unlawful as it was in response to the Union's election victory. *See St. John's Community Services*, 355 NLRB No. 70, slip op. at 2 fn. 3 (2010) (citing *Southern Mail, Inc.*, 345 NLRB 644 (2005)).

<sup>34</sup> In Exception 37, Respondent claims that the ALJ erred by failing to acknowledge that Dande was disciplined for charting that she gave vitamin B to a patient and that she was therefore treated the same as Claudio. Respondent is wrong that they were treated similarly. First, Claudio was not terminated for documenting that she gave a medication that she did not in fact give. Second, Dande received merely a second written warning even though she had three prior written warnings including a final written warning. (R-83, R-85, R-93, R-98.) In Exception 72, Respondent misstates the ALJ's finding. *See* ALJD at 47.

fact, she missed only one day as she was absent for one of those two days. Patty Beck, the employee who actually failed to chart the patient post-fall on the second day, received no discipline for that omission.

On November 5<sup>th</sup>, Southgate was directed by Konjoh to issue Jacques a written warning regarding an incomplete incident report, even though Jacques had previously informed Konjoh by telephone that she was unable to complete the report before the end of her shift. (Tr. 2223-24.) Southgate testified that this discipline was not deserved. (Tr. 985.) Engram's testimony buttressed Southgate's view; she testified that when a nurse fails to complete an incident report or admissions documentation, the proper procedure is to have the nurse subsequently complete the documentation. (Tr. 1981-82.) Konjoh did not follow the proper procedure and ensure that the documentation was complete and correct.

On February 10, 2011, Jacques was discharged for incidents that occurred on December 7<sup>th</sup>. On that day, Jacques served as charge nurse during an unusually hectic evening with many new admissions and broken fax machines that made it difficult to obtain medications from the pharmacy and fax information to the physician. (Tr. 578, 580.) Two days later, Jacques was suspended and ultimately terminated for transcribing an order for aspirin inaccurately, failing to transcribe it on the MAR and not completing admission paperwork.

Engram testified that the aspirin transcription error Jacques made would not have harmed the patient. As noted by the ALJ, she testified that giving regular rather than enteric aspirin to a patient would be harmful only if given over a period of time to a patient with a history of GI bleed. (Tr. 1888.) She further testified that the patient at issue had no such history. (Tr. 1975.) Further, both Engram and Southgate corroborated Jacques' testimony that Jacques' transcription error regarding the aspirin should have been discovered during the 24 hour chart check on the

next shift. (Tr. 996.) Engram testified that the purpose of the 24 hour chart check was to make sure medications were correctly recorded and that if the nurses on the 11-7 shift were doing their job, they would have caught Jacques' aspirin medication error. (Tr. 1975-80.) Engram further testified that the nurse who did not catch the error on the 11-7 shift should have been disciplined; however, Engram could not identify any nurse who was disciplined for the chart check failure nor was any such discipline presented by Respondent. (Tr. 1977.) Notably, the DHSS Plan of Correction also required this chart review. (CP-1.)

Moreover, the documentation errors made by Jacques were common and other nurses who committed such errors were not discharged even if they had prior disciplines. Conteh Salaimatu received a verbal notice for failing to transcribe a physician's telephone order to the POS and the MAR. (R-89.) Significantly, on November 29<sup>th</sup>, Jeremias Santos received two verbal notices—one for administering medication without a proper order and another for failing to complete multiple admission documents. (GC-111; R-91.) These low level disciplines are in stark contrast to the discipline imposed on Jacques.

In an effort to distinguish this stark disparate treatment, Respondent argues that the ALJ failed to acknowledge Respondent's adherence to a progressive discipline policy and the employees' disciplinary history. (Exception 39.) It argues that Jacques received a final warning in December 2009 and that Respondent could have fired her for the next infraction. First, that warning was the first warning Jacques received in her eleven years of employment. (R-10.)<sup>35</sup> Second, Konjoh testified that when issuing discipline, she did not take into consideration any

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<sup>35</sup> Under the section for prior disciplines, a symbol for zero was entered. (R-10.) Respondent argues in its brief that this December 2009 warning for pain assessment was the same issue for which Respondent received a "G" level deficiency in 2009. Resp. Br. at 30. This incident is discussed in R-33, the State survey. The State found that the facility failed to assess the resident for pain for twenty days; Jacques admitted the patient into the facility but had no contact with the patient after admission. (Tr. 672-73.)

disciplines the nurse received prior to Konjoh's arrival in August 2010. (Tr. 2575.)<sup>36</sup> Thus, the disciplines that would have been considered prior to her discharge were a first written warning in September 2010 and another warning in December 2010.<sup>37</sup> Third, the effect of a "final" written warning on subsequent disciplines is unclear from the record. Respondent's progressive discipline policy makes no mention of a "final" warning. (R-40 at 22-23.) At one point Konjoh testified that the step after final warning is termination. (Tr. 2580.) However, employees received "final warnings" that were followed by written warnings. (R-85, R-93, R-98, R-83, G-19, R-86.) Finally, all disciplines issued to Jacques after Konjoh's arrival were for documentation errors—none of which resulted in harm to a patient.

#### **4. Disparate treatment of Napolitano, Claudio and Jacques**

Unlike Napolitano, Claudio and Jacques, other nurses who committed even more serious transgressions were either not disciplined or received lesser disciplines. It is well-settled that more lenient treatment of employees who have engaged in more egregious conduct than the discriminatee constitutes evidence of pretext. *See, e.g., Pro-Spec Painting, Inc.*, 339 NLRB 946, 950 (2003) (evidence of disparate treatment of discriminatee "supports the inference that the reasons advanced" for the adverse employment action "were pretexts" and that the employer's conduct was "in fact caused by [discriminatee's] union activities"); *Camaco Lorain Mfg.*, 356 NLRB No. 143 (2011), slip op. at 4 (employee who engaged in more egregious misconduct was treated more leniently than discriminatee, refuting Respondent's defense that it would have

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<sup>36</sup> Konjoh further testified that final warnings issued to Jacques and Napolitano did not play any part in disciplines she issued. (Tr. 2577.)

<sup>37</sup> The record is unclear as to whether this was a final warning. There were two copies of the warning in evidence, GC-46 and R-88. Despite the ALJ's request for the original, Respondent never produced it. (Tr. 2231-32.)

discharged discriminate in the absence of protected activity); *George P. Bailey & Sons, Inc.*, 341 NLRB 751, 756 (2004); *Teledyne Advanced Industries*, 332 NLRB 539 (2000).

The ALJ carefully considered the disciplinary records of other nurses and found that other nurses were treated more leniently than Napolitano, Claudio and Jacques. For example, the ALJ noted the lengthy disciplinary record of Doreen Dande that included more serious infractions than committed by Napolitano, Claudio and Jacques. Dande received a final written warning followed by three more written warnings before resigning. Clearly, a progressive discipline policy was not followed here. Remarkably, on November 26, 2010, Dande falsified a record by signing the MAR that Vitamin B was given to a patient when, in fact, it clearly was not. This error was discovered not by the close monitoring of the MAR, as had been done with Claudio, Napolitano and Jacques, but because the resident had reported the error to the physician who requested a medication error report. (R-83; Tr. 2175-78.) For this fourth infraction in two months, Dande received merely a second written notice.

Beck falsely documented that treatment patches were removed, when in fact they were not. She received only a written notice for this on September 10<sup>th</sup>. (R-94.) Two weeks later, she received only a verbal warning on September 28<sup>th</sup> for failing to do admission charting. Thereafter, Beck received only a verbal notice for failing to complete incident reports for two incidents and failing to include the nursing assistant statements. (GC-114.)<sup>38</sup> Again, in February 2011, Beck falsely documented that she completed a patient dressing when the prescribed medicinal paste was not administered and received a final written warning. (R-69.) The record is replete with other examples of disparate treatment, with nurses receiving lesser discipline than

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<sup>38</sup> Jacques received a written final warning for a similar infraction. (GC-46.) Like Beck, Bisong received a verbal warning for incomplete incident reports. (GC-115.)

the Union supporters.<sup>39</sup> The ALJ cited example after example of employees who received lesser discipline for similar or even more severe errors.

Further, the record reveals that medication errors and documentation errors and omissions were common at Somerset. Nurses were repeatedly in-serviced over MARs and TARs that were left blank and repeatedly instructed that the 24 hour chart review was “a must.” (CP-1, CP-2, CP-5, R-15.) Nurses were responsible for up to twenty patients,<sup>40</sup> all of whom are prescribed numerous medications which could amount to up to fifteen medications per patient. (Tr. 2536-37.) Generally, the nurse spends two hours dispensing medication for each medication pass. (Tr. 2537.) In addition, nurses are required to administer treatments, admit patients and handle a myriad of issues during their hectic shifts. Thus, given the pace and workload of the nurses, the 24 hour chart check was critical to catch the documentation omissions and errors that were bound to occur and which did routinely occur as evidenced by the testimony of Southgate and the discriminatees, as well as the in-service documents and nurses meeting agendas.

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<sup>39</sup> Both Bockarie and Jacques testified to a significant error Bockarie committed when he failed to administer coumadin to a patient in December 2010. Bockarie, who corroborated Jacques, had no motive to lie about a serious error he committed. Konjoh disputed Jacques’ testimony that Jacques reported the error to her the next day, told Konjoh that the physician, Dr. Paris, wanted a written incident report and that Konjoh replied that she took care of it. Respondent challenges Jacques’ credibility on this issue, claiming the General Counsel never introduced into evidence the 24 hour report which Jacques stated referenced this error. (Resp. Br. at 83.) Respondent’s counsel is well aware that those reports were subpoenaed by counsel for the Charging Party, not the General Counsel, and that the 24 hour report books contained missing pages. Respondent’s counsel did not offer the reports into evidence to impeach Jacques presumably because the missing pages rendered the books unreliable. Finally, Respondent’s attempt to discredit Jacques because she was not sure of the exact date of the coumadin incident or whether it preceded the B-12 incident was ineffective. While Jacques could not recall the precise date of the incident and was not clear whether it was before or after another medication error committed by Bockarie in the same general period of time, her testimony concerning the incident was specific and her affidavit stated that the error was committed “about December 31.” (Tr. 650.) Respondent’s attempt to discredit Jacques on the basis that Konjoh left for vacation on December 29<sup>th</sup> is unavailing.

The special treatment that Bockarie received is well documented by the minor disciplines issued to him as well as by his close relationship with Illis.

<sup>40</sup> For example, GC-51, a daily assignment sheet, reflects that each nurse was assigned to ten to eleven rooms. Each room had 2 patients when the census was full.

The disparate treatment of Napolitano, Claudio and Jacques, who were treated far more harshly than other nurses, demonstrates that Respondent would not have disciplined and terminated their employment absent animus toward their Union activity and that the reasons proffered for their discipline were pretextual. *See, e.g., Pontiac Care & Rehabilitation Ctr.*, 344 NLRB 761 (2005). Further, that Respondent began issuing disciplines for documentation errors after the election to other employees does not render its conduct lawful as the Board has recognized such conduct as an attempt to cover up retaliatory disciplines. *Bay Corrugated Container, Inc.*, 310 NLRB 450 (1993).<sup>41</sup> Accordingly, Respondent has failed to rebut the General Counsel’s case that these employees were unlawfully discharged for their Union activity.

### **III. THE ALJ CREDIBILITY FINDINGS ARE SUPPORTED BY THE RECORD.**

Respondent excepts to the ALJ’s failure to credit its witnesses Hutchens, Illis and Konjoh over the witnesses presented by the General Counsel. Respondent has failed to show by a clear preponderance of all the relevant evidence that the ALJ’s credibility resolutions were incorrect.<sup>42</sup>

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<sup>41</sup> Respondent claims that nurses were disciplined prior to the commencement of any Union activity. While there were a few disciplines issued, they were rare and not for issues relating to MARs and TARs documentation; those documentation shortcomings were common and handled with reminders at nursing meetings. Napolitano and Jacques received disciplines right after the December 2009 survey relating to pain assessment—the deficiency cited by the State. The only other disciplines in the record prior to July 2010 were verbal warnings issued to Michelle Moore for serious nursing infractions such as failing to report a significant patient change and failure to check the alarm for a patient on a falls prevention program. (GC-118, 119.)

<sup>42</sup> Respondent challenged the ALJ’s credibility findings based on minor discrepancies that were not material to the ALJ’s conclusions. For example, it claims the ALJ erred by crediting Onyeike’s testimony because Onyeike described Konjoh as “short and light-skinned.” Contrary to Respondent’s claim, from Onyeike’s perspective, Konjoh may have appeared light-skinned—a perspective not contradicted by Konjoh’s passport photo. Respondent also claimed that the ALJ contradicted himself by stating that Respondent took no affirmative steps relating to changes in administration or increased oversight following the December 2009 survey, when he earlier noted that the Regional nurses (whom Hutchens testified regularly visited Care One facilities) were brought in for the recertification survey in January 2010. (Exception 11, Resp. Br. at 53-54.) The significant finding here was that despite

As a preliminary matter, a large number of the Exceptions misstate and misquote the findings of the ALJ.<sup>43</sup> The ALJ's crediting of General Counsel's witnesses, including Southgate, Napolitano, Claudio and Jacques,<sup>44</sup> over contradictory testimony of Respondent's witnesses was fully supported by the record.

Illis's credibility on almost every topic about which she testified was contradicted by record evidence. Her testimony regarding her knowledge of the Union's organizational efforts ranged from a curious memory lapse to blatant misrepresentation. She testified repeatedly that she was not aware that employees had been talking about bringing in a union when she accepted the position as administrator, and that she first learned that union organizing was going on at Somerset Valley after she accepted the position when she arrived at Somerset Valley on August 3<sup>rd</sup>. (Tr. 2673, 3071.) This testimony is contradicted by Respondent's privilege log produced in response to the General Counsel's subpoena, which reveals that Illis was the recipient of a July 28<sup>th</sup> email from Respondent's attorneys regarding legal advice and analysis regarding the NLRB petition. (GC-141.) Her credibility was further impeached when she was presented with prior testimony from the objections hearing in which she admitted that she was aware that employees were trying to bring a union to Somerset Valley prior to her arrival at Somerset on August 3<sup>rd</sup>. (Tr. 3071-72.) Her initial denial of knowledge was so incredible that Hutchens testified he was certain Illis knew about the Union petition before she arrived at Somerset. He

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Respondent's claim that Heedles and the director of nursing were inadequate and the business was in crisis after the 2009 state survey, Respondent took no significant action to remove them until after the petition was filed.

<sup>43</sup> For example, in Exceptions 20, 27, 30, 33, 70, 71, 72 and 73, Respondent claims the ALJ made certain findings when the ALJ simply described a particular witnesses' testimony.

<sup>44</sup> Charging Party has limited this brief to the issues surrounding the discharges of Napolitano, Claudio and Jacques, and therefore does not address Respondent's claims regarding the credibility of witnesses who testified about the other violations of Sections 8(a)(1) and (3).

testified, “I know she was informed of the Union petition . . . before she got there. It’s just, you know, there’s no way we would, you know, not tell someone that.” (Tr. 1660.)

Hutchens’ testimony concerning Respondent’s knowledge of union activity and support was similarly lacking in credibility. He testified that in his “opinion,” the employees in the Union’s flyer, GC-10, did not support the Union, even though the flyer said they were voting “yes” and contained statements from each employee as to the reasons for their support of the Union. When asked the basis for his belief that all the employees in the flyer did not support the Union, he provided preposterous and evasive responses. First, he replied that the flyer was distributed in August but the photos looked as if they were taken in the spring; thus, he believed people on the flyer did not support the Union in August. (Tr. 1662-63.) He then stated that he could tell who did not support the Union by the demeanor of employees but tried to backtrack, so as to conceal Respondent’s knowledge, and testified that he really did not know if they supported the Union or not. (Tr. 1662-64.) His effort to conceal Respondent’s knowledge was disingenuous given that the Union publicized employee support and that management regularly met to track Union sympathies of employees on the Excelsior List and polled and interrogated employees.

The ALJ also properly credited the witnesses called by the General Counsel over Konjoh. Her testimony on cross-examination was evasive and vague on details when they did not support Respondent’s case, and she minimized the significance of errors committed by nurses who were not discriminatees. (Tr. 2462-76.) She contradicted her own direct examination testimony when she claimed on cross examination that she was not sure the physician Dr. Paris ordered a medication error report on Dande’s B-12 error. (Tr. 2176, 2481.) Incredibly, she denied that blank MARs and TARs were a problem despite that it was a repeated agenda item on in-service

meetings and nurses meetings held while she was a DON. (Tr. 2552-53, R-3, R-15, CP-2, CP-5.) Similarly, her testimony that she was not aware of the 24 hour chart check on the 11-7 shift is contradicted by agendas for nursing meetings held while she was the DON, which state that the 24 hour chart check is “a must” on the 11-7 shift. (CP-2; CP-5, R-15.)<sup>45</sup> Finally, her conduct around the zinc incident with Napolitano and attempt to falsely claim that Claudio failed to administer treatments on October 7<sup>th</sup> are further evidence of her lack of credibility and trustworthiness. *See above* at 14 fn. 19 and at 19.

**IV. RESPONDENT’S CLAIM THAT THE DISCIPLINES AND DISCHARGES OF NAPOLITANO, CLAUDIO AND JACQUES WERE NOT DUE TO THEIR UNION ACTIVITY BUT RESULTED FROM NEW MANAGEMENT’S EFFORT TO IMPROVE PATIENT CARE IS DISINGENUOUS.**

The evidence overwhelmingly contradicts Respondent’s contention that Illis and Konjoh replaced the prior administrator and DON in August 2010 to improve patient care and not in response to the unionization effort. First, the timing immediately following the petition could not be more suspect. Although Respondent claims that the poor results of the annual DHSS survey led to Heedles’ removal (Tr. 1423), the survey was conducted eight months prior to Care One’s removal of Heedles. As discussed above, the replacement of Heedles by Illis, who served as the administrator of another Care One facility that was only half the size of Somerset, was abrupt and took place just days after the representation petition was filed. (Tr. 1506.) Second, after her arrival, Illis took action to address employee complaints, including her immediate reversal of Heedles’ radical scheduling changes, previously ignored by Care One.

Third, as detailed above, Respondent’s claim that it had to quickly address serious clinical problems at Somerset is contradicted by record evidence of Care One’s close monitoring of clinical operations. Although Illis testified on direct examination that she came to Somerset to

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<sup>45</sup> CP-5 and R-15 refer to the 24 hour chart check in item 5 of the agenda.

improve the poor performance at that facility, she sent a memo to employees on August 30<sup>th</sup> in which she stated that Somerset had a “first class” reputation and that “the team does not accept second best when it comes to providing care to the residents.” (Tr. 3110-11, GC-12.) On cross-examination, Illis testified that these statements were in fact true. (Tr. 1310-11.)

Fourth, in an attempt to buttress Respondent’s claim that Illis became Somerset’s administrator solely to improve patient care, Illis lied about her knowledge of the Union’s petition prior to her arrival at Somerset, falsely claiming she had no knowledge of the Union petition prior to August 3<sup>rd</sup>. *See above* discussion in Section III. It can be inferred from this false testimony, as well as other record evidence, that she was placed at Somerset to implement Care One’s campaign to discourage employees from supporting the Union. As described above, Respondent devoted enormous resources and time to its anti-union campaign during the entire month of August, with almost daily management meetings to assess employee Union sympathy and numerous anti-union meetings where employees were pulled away from their duties to view videos and power point presentations and listen to management’s anti-union pitch. There is no evidence that Respondent devoted similar resources in August to meet with employees concerning clinical issues.

Fifth, Care One would not have placed an inexperienced Konjoh—who lasted only five months as the DON—if clinical shortcomings were significant, nor would it have waited eight months after the 2009 survey to replace the administrator. Not only did Konjoh place a resident at risk in her campaign to remove Napolitano and the other leaders of the Union’s organizing efforts and fail to follow through on her responsibilities as described by Engram, she testified that she did not require nurses to perform the 24 hour chart check and ignored a DHSS Plan of Correction, adopted in April 2010 in response to a DHSS survey conducted on March 12, 2010.

(CP-1 at 4; GC-88.) This Plan of Correction required that the 11-7 shift check daily for completion of MARs/TARs. Illis testified that Somerset would be required to follow the Plan of Correction and perform this daily check (Tr. 3071.), and Engram testified that Care One facilities are required to perform 24 hour chart checks to prevent transcription and medication errors (Tr. 1975). Yet Konjoh testified that she was not aware of the Plan of Correction and did not follow it. (Tr. 2547-48.) Nor did she follow the Care One practice of performing a chart check to prevent errors, despite considerable record evidence from in-services that blank MARs and TARs were a continuing problem.

Finally, Respondent's apparent claim that infractions which may have been tolerated in the past were no longer tolerated under Illis's regime is contradicted by the fact that Care One had maintained close oversight of the operational and nursing practices of the facility and did not discipline nurses prior to the election for the type of infractions for which the discriminatees were disciplined, as well as by the disparate treatment of the discriminatees following the election.

In view of all of the evidence including the timing of Respondent's action, disparate treatment of the discriminatees and its pretextual defenses, Respondent has fallen far short of proving that it would have discharged Napolitano, Claudio and Jacques in the absence of their protected activity in support of the Union.

**V. THE ALJ FINDING THAT THE EMPLOYEES SHOULD BE REINSTATED IS REQUIRED UNDER BOARD LAW TO REMEDY RESPONDENT'S UNLAWFUL CONDUCT.**

Respondent challenges the ALJ's recommended order directing Respondent to offer reinstatement to Sheena Claudio, Jillian Jacques and Shannon Napolitano, claiming that

reinstatement is not an appropriate remedy. (Exception 106.) Respondent’s exception lacks any legal basis.

The ALJ correctly stated that, when considering health care facilities, the issue is how Respondent deals with its employees who engage in union activities as compared with other employees. *See* ALJD at 43; *St. John’s Community Services—New Jersey*, 355 NLRB No. 70, slip op. at 10, 11 (2010) (“*St. John’s*”). Accordingly, in *St. John’s*, the Board affirmed the reinstatement of an employee who had committed a medication error, finding that the employer failed to show that it would have terminated the employee regardless of the protected activities. As explained by the ALJ, “having discriminatorily discharged [the employee], it *must* offer her reinstatement. *See id.* at 14 (emphasis added). As in the instant case, the employer conceded that in the past, it did not consistently issue disciplines to employees for documentation errors. *Id.* at 11.

Notably, the single Board decision to which Respondent cites regarding reinstatement, *Family Nursing Home & Rehab. Ctr.*, 295 NLRB 923 (1989) (“*Family Nursing Home*”), actually *supports* reinstatement of Claudio, Jacques and Napolitano. Respondent ignores in *Family Nursing Home* that the Board affirmed reinstatement for employee Ingvaldstad, who had allegedly failed to complete patient treatments. *See Family Nursing Home* at 929, 932. In so doing, the ALJ found that there was no valid justification for her discharge and that she was discharged for protected and concerted activity. *Id.* at 930. The ALJ also noted a past practice of simply leaving the patient chart blank where treatments were incomplete, with the next shift making up the treatment.<sup>46</sup> *See id.* at 929.

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<sup>46</sup> The record in the instant case reveals that documentation errors, including the failure to document on MARs and TARs, were widespread prior to the election and that disciplinary measures were not taken against the employees.

Contrary to Respondent’s description of the case, only one employee in *Family Nursing Home* was refused reinstatement—an employee who had, upon termination, threatened the director of nursing with a bowling trophy and refused to leave the premises until the employer called the police. *See id.* at 928. The Board relied solely on this post-discharge behavior to deny reinstatement, explicitly stating that the Board “denies reinstatement in those flagrant cases in which the misconduct is violent or of such character as to render the employee unfit for further service.” *See id.* at 923 fn.2. As such, *Family Nursing Home* provides only a narrow exception to reinstatement—an exception which is inapplicable to the instant case—where a health care employer has terminated an employee for union activity.<sup>47</sup>

Federal courts have upheld the reinstatement of employees in health care facilities, even where allegedly serious substandard nursing practices resulted in a patient’s death. *See Boston Med. Ctr. v. SEIU, Local 285*, 260 F. 3d 16, 19 (1st Cir. 2001). In *Boston Med. Ctr.*, the United States Court of Appeals for the First Circuit considered the policy exception to enforcement of an arbitral award (including reinstatement), which allows a court to refuse to enforce an award where it is contrary to an explicit and defined public policy. *See Boston Med. Ctr.* at 23. The Court stated that such policy is to be ascertained by reference to laws and legal precedents, and

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<sup>47</sup> One Board member noted the nature of the nursing home business, but only with regard to the violent employee post-discharge behavior. *See Family Nursing Home* at 923 fn.2.

Respondent’s reliance on *Hoffman Plastic Compounds v. NLRB*, 535 U.S. 137 (2002) (“*Hoffman*”) and *Beth Israel Hospital v. NLRB*, 437 U.S. 483 (1978) (“*Beth Israel*”) is similarly displaced. In *Hoffman*, the issue was whether the Board could award backpay to undocumented workers. The U.S. Supreme Court emphasized the serious and illegal nature of the misconduct in violation of the Immigration Reform and Control Act, stating that allowing backpay in that case would have awarded to an illegal alien wages which could not lawfully have been earned and for a job obtained by a criminal fraud. *See Hoffman* at 146, 149.

At issue in *Beth Israel* was a hospital’s rule prohibiting employees from soliciting union support and distributing union literature in the hospital cafeteria and coffeeshop during nonworking time. The U.S. Supreme Court affirmed enforcement of the Board order requiring the hospital to rescind its rule, noting that the employees’ interests—as here, their § 7 rights—were at their strongest. *See Beth Israel* at 504, 507.

not from general considerations of supposed public interests. *See id.* (citing *United Paperworkers Int'l Union v. Misco, Inc.*, 484 U.S. 29, 43 (1987)). The Court then clarified the question as whether the reinstatement, and not the nurse's conduct, violated an explicit public policy in favor of competent nursing care, and held that there was no such public policy prohibiting reinstatement under the circumstances at hand.<sup>48</sup> *See id.* at 23, 25.

Regardless, in discussing patient safety and care concerns generally, the Respondent cites to two inapposite Board decisions. Resp. Br. at 84. First, in *Vencor Hospital—Los Angeles*, 324 NLRB 234 (1997) (“*Vencor*”), the ALJ explicitly found that the employer would have discharged the employee at issue even if he had not engaged in union activities. *See Vencor* at 251. For the reasons previously discussed, this is not the case here. Similarly, *Jupiter Medical Center Pavilion*, 346 NLRB 650 (2006) (“*Jupiter*”) is inapposite. In *Jupiter*, the Board affirmed the ALJ's finding that the discipline for deficient patient care would have been issued regardless of the employee's union activities. *See Jupiter* at 659. In reaching that finding, the ALJ considered the employer's “five star” rating—the highest—by the authority which accredits nursing homes, and that the employee's immediate supervisor was a diligent nurse who imposed high standards. *See id.* Unlike the instant case, there was no evidence of inconsistent or disparate discipline.

Neither of these cases addresses the issue of reinstatement of employees who have been discriminatorily discharged. Rather, as *St. John's* makes clear, reinstatement is mandatory under Board law where the employer has terminated employees for protected activity. Nor has

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<sup>48</sup> The Court further noted that there was no finding of incompetence or inability to properly carry out the basic responsibilities of an RN, nor of a propensity to engage in multiple bad acts or an unwillingness to modify behavior. *Id.* at 26.

Respondent identified any competing federal policy that overrides that of the rights protected under the NLRA. Accordingly, the ALJ's recommended remedy is fully consistent with well-established law.

### CONCLUSION

For the forgoing reasons, Charging Party respectfully requests that the Board reject all of Respondent's Exceptions and adopt the Administrative Law Judge's findings of facts and conclusions of law that Respondent violated Sections 8(a)(1) and (3) of the Act.

Dated: New York, New York  
February 29, 2012

Respectfully submitted,



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Ellen Dichner  
Jane Chung  
GLADSTEIN, REIF & MEGINNISS, LLP  
817 Broadway, 6th Floor  
New York, NY 10003  
(212) 228-7727

Counsel for 1199 SEIU United Healthcare  
Workers East, New Jersey Region

## CERTIFICATE OF SERVICE

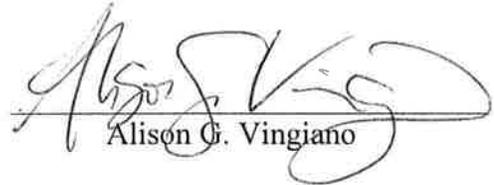
This is to certify that on February 29, 2012, Charging Party 1199 SEIU United Healthcare Workers East's Answering Brief to Respondent's Exceptions to the Decision of the Administrative Law Judge was filed electronically and served as follows:

Lester A. Heltzer  
Executive Secretary  
National Labor Relations Board  
1099 14<sup>th</sup> St., N.W.  
Washington, D.C. 20570

Jay Kiesewetter, Esq.  
[jkiesewetter@littler.com](mailto:jkiesewetter@littler.com)

Saulo Santiago  
[saulo.santiago@nlrb.gov](mailto:saulo.santiago@nlrb.gov)

Dated at New York, New York this 29<sup>th</sup> day of February, 2012.

  
Alison G. Vingiano