

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
DIVISION OF JUDGES
NEW YORK BRANCH OFFICE

GAYLORD HOSPITAL

and

Case Nos. 34-CA-13008
34-CA-13079

JEANINE CONNELLY, An Individual

Rick Concepcion, Esq. and Claire T. Sellers, Esq.,
Hartford, Connecticut, for the Acting General Counsel
Brian Clemow, Esq. and Jarad M. Lucan, Esq.,
Shipman & Goodwin, LLP for the Respondent

DECISION

Statement of the Case

LAUREN ESPOSITO, Administrative Law Judge. Based upon charges filed on June 9, 2011 and August 15, 2011, by Jeanine Connelly, an Individual ("Connelly"), a Consolidated Complaint and Notice of Hearing issued on September 30, 2011. The Complaint alleges that Gaylord Hospital ("Gaylord" or "Respondent") violated Section 8(a)(1) of the Act by issuing a written warning to Connelly on April 1, 2011, suspending her on April 5, 2011, and discharging her on April 8, 2011 in retaliation for her protected concerted activities. The Consolidated Complaint also alleges that Respondent violated Section 8(a)(1) by prohibiting employees from discussing their terms and conditions of employment, and by threatening them with job loss in retaliation for their protected concerted activities. Respondent filed an Answer denying the material allegations of the Complaint. This case was tried before me on January 9, 10, 11, and 12, on February 27 and 28, on March 12, 13, 14, and 15, and on April 10, 11, 12, and 13, in Hartford, Connecticut.

On the entire record, including my observation of the demeanor of the witnesses, and after considering the briefs filed by the Acting General Counsel (the "General Counsel") and Respondent I make the following

Findings of Fact

I. Jurisdiction

Respondent is a non-profit corporation with an office and place of business in Wallingford, Connecticut, where it operates a hospital providing inpatient and outpatient medical care. Respondent admits and I find that it is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act.

II. Alleged Unfair Labor Practices

A. Background

5 Respondent operates a long-term acute care health facility, which provides health care services similar to an acute care hospital. Respondent is licensed by the State of Connecticut as a chronic disease hospital, and is recognized by the federal government’s Center for Medicare and Medicaid Services as a long-term acute care hospital. Respondent’s patients are generally medically complex patients with several different conditions, who therefore require longer-term inpatient care. Respondent employs hundreds of employees, the majority of which, over 200, comprise its nursing staff. The events at issue in this case took place in the Respiratory Therapy Department, which consists of approximately 20-30 employees, the majority of whom are Respiratory Therapists (“RTs”).

15 Respondent’s clinical operations are overseen by Chief Medical Officer Dr. Louis Teba, who is responsible for all clinical care matters. The Medical Director for Respiratory Care, who reports to Dr. Teba, is responsible for clinical care in the Respiratory Therapy Department; during the events at issue in this case the Medical Director for Respiratory Care was Dr. Brett Gerstenhaber. Dr. Gerstenhaber was not an employee of Gaylord, but part of a group which contracts to provide services at the hospital. Charlotte Hyatt is Respondent’s Vice President of Clinical Services, and the Director of the Respiratory Therapy Department reports to her. At the time of the events at issue here, the Director of the Respiratory Therapy Department was Paul Trigilia, who left his employment with Respondent in June 2011.¹ The RTs are directly supervised by the Respiratory Therapy Department’s Supervisor. Michael Burke was the Respiratory Therapy Department Supervisor from March 15, 2011 until December 9, 2011, when he resigned.² Prior to becoming supervisor of the Department, Burke worked for Respondent as an RT on a per diem basis. Respondent admitted in its Answer and I find that Hyatt, Trigilia, and Burke were supervisors within the meaning of Section 2(11) of the Act, and stipulated at the hearing that Gerstenhaber was an agent of Respondent within the meaning of Section 2(13) of the Act. Hyatt, Gerstenhaber, Trigilia and Burke all testified at the hearing.

35 Susan Hostage is Respondent’s Director of Outcomes Management, and reports to Dr. Teba as well as to Respondent’s President and Chief Financial Officer. Hostage is responsible for performance improvement, risk management, customer satisfaction, accreditation, licensure, and regulatory compliance issues. Hostage testified at the hearing. Rena Susca is a supervisor in Respondent’s Information Services Department, and testified at the hearing as well.

40 Walter Harper is Respondent’s Vice President of Human Resources, and Bryana Minor, an Employment Administrator, reports to him. Respondent admitted in its Answer and I find that Harper is a supervisor within the meaning of Section 2(11) of the Act, and stipulated at the hearing that Minor is an agent within the meaning of Section 2(13). Harper and Minor both testified at the hearing.

45 The Charging Party, Jeanine Connelly, was employed by Respondent as a Respiratory Therapist. Connelly initially worked for Respondent on a per diem basis from November 2008 until August 2009, and was then employed full-time until her discharge on April 8, 2011. Respiratory Therapists Teresa Charland, Marlene Slowenski, and William Hutson, all currently employed by Respondent, testified at the hearing as well.

50 ¹ Trigilia was replaced as Director of the Respiratory Therapy Department by Jerry Schlette.

² Donna Ward was the Supervisor of the Respiratory Therapy Department prior to Burke.

B. The Operations of Respondent's Respiratory Therapy Department

5 Respondent's Respiratory Therapists are responsible for treatments and procedures
involving patients' respiration, including administration of medication through nebulizers or
inhalers,³ breathing exercises, arterial blood gas and other testing, maintenance of
tracheostomy tubes and other medical devices, and maintaining and weaning patients off of
10 ventilators. The instant case involves an arterial blood gas, or ABG, test. These tests are often
ordered to be performed by the RTs in the morning. In order to perform an ABG test, the RT
draws blood from the patient, placing a needle bevel up into the artery after washing an
appropriate area of the skin down with alcohol. After the blood is drawn, pressure is applied to
the area with gauze. The blood is then taken on ice to a machine which measures the amount
15 of oxygen, carbon dioxide, and other gases it contains.

15 Respondent's facility has several buildings. RTs cover patients in the Hooker, Lyman,
and Milne buildings, each of which has two floors. The Milne building was opened in December
2008, and while, according to Hyatt, the overall patient census did not increase dramatically, the
general acuity level of the patients may have increased as a result. Each day shift typically has
20 four RTs, one of which covers the Hooker building, one of which covers the Lyman building, and
two of which cover the Milne building, with one RT assigned to each floor.

RTs are also responsible for entering information into patient medical records in
connection with the procedures and tests they perform. Information Services Department
25 supervisor Rena Susca explained that patient records are created through the Meditech
software system, which encompasses all information from the time of the patient's admission,
including laboratory tests, medications, physicians' orders, and billing. Medical orders are
primarily entered into the Meditech system by physicians through its provider order
management module. However, RTs can also enter physicians' orders through the provider
30 order entry module. In order to do so, the RT must sign into the computer and the Meditech
system with their own user name and password, proceed to the order entry module, and choose
the enter orders routine. The system will then prompt them to enter the ordering physician,
which they must do to proceed to enter the order. RTs are trained on the Meditech system
when they begin their employment with Respondent, and provided with written reference
35 materials about the system. Trigilia and Burke also testified that they were available for
consultation in case of specific problems involving Meditech, and Charland testified that she
once called Burke at home for assistance with a particular issue. Nevertheless, it is evident
from the testimony of Connelly, Charland, and Hutson that the RTs encountered difficulties with
the use of the Meditech system. In Connelly's performance appraisal for the calendar year
40 2010, dated December 8, she was encouraged to become more proficient in Meditech.

The RT Department holds weekly meetings to discuss clinical and employment-related
issues. These meetings include the Director and Supervisor of the Department. Hyatt testified
45 that she has also attended the majority of the weekly RT Department meetings since 2009.
Minutes are prepared of each meeting, which are available in the RT Documentation Room for
the RTs to review in the event that they are unable to attend.

50 ³ Because medication is so often administered by RTs through such devices, the words
"medication" and "treatment" are generally used interchangeably.

C. Evidence Pertaining to Connelly’s Protected Concerted Activities

The evidence establishes that a number of the RTs have had concerns regarding staffing levels and workload since 2009. According to Hyatt, Respondent considered budget cuts and reductions in staff due to a decreased patient census during the summer of 2009. In response, the RTs, including Connelly, drafted a letter which was sent to Paul Cullen, Respondent’s Chief Executive Officer at the time, Hyatt, Teba, Hostage, and other managers, expressing their concerns regarding the workload and the impact of possible staff reductions on patient care.⁴ In response, a meeting was arranged, which Cullen and Hyatt attended, to discuss the RTs’ workload and the possible reductions in staff. Hyatt recalls that RT Anne Marie Iosa was the most vocal employee at the meeting. Slowenski testified that Connelly discussed scheduled medications which were being missed, or not administered, by the RTs as a result of their workload overall.⁵

Hyatt testified that the proposed reductions were not ultimately implemented because the patient census increased again. In response to the RTs’ concerns, she began meeting with Trigilia to review the RTs’ workload and productivity, and to determine whether additional RT Department staff was necessary. Slowenski testified that after the meeting, Respondent began assigning overtime to the RTs, and created a new “helper” position to handle morning treatments for patients in the Milne building. The evidence establishes that no RT has been laid off since the Milne building opened.

The record also establishes that scheduling and “call-outs” were an ongoing issue in the RT Department. When an RT called in on the morning of their shift and stated that they would not be reporting to work, coverage had to be arranged for that RT’s patients and duties, either by obtaining a per diem or by dividing the work among the other RTs at work that day. This issue was addressed at several of the RT Department weekly meetings in December 2010 and February 2011, with various proposals advanced by the RTs in order to ameliorate the problem. Connelly spoke at these meetings regarding the ongoing call-out issue and possible incentives for RTs to reduce the number of call-outs. Connelly testified that she repeatedly raised this issue with Trigilia outside of the weekly meetings, and Hutson testified that other RTs, including Iosa, Nancy Grenier, Tammy Maher, Richard MacGillivray, and himself, spoke to Trigilia regarding scheduling and call-outs as well. In addition, Connelly spoke to Teba on several occasions regarding workload, staffing, and scheduling issues involving the RT Department.

⁴ The preponderance of the evidence does not establish that this letter was forwarded to Cullen and the other managers with Connelly’s signature. I credit the testimony of Susan Hostage authenticating the signature sheet in evidence as Respondent’s Exhibit 8. In addition, Hutson, who also participated in drafting the letter, testified that he could not be certain as to whether or not Connelly signed it. I find this evidence to be more probative overall than Connelly’s testimony that she signed the letter, and her assertion that the signature sheet in evidence as Respondent’s Exhibit 8 is missing the names of other RTs employed by Respondent at the time.

⁵ General Counsel argues that at this meeting Trigilia denied that he was aware of a problem with missed medications, and that Connelly’s statements regarding missed medications contradicted him, embarrassing him in front of Hyatt. General Counsel argues that this episode engendered Trigilia’s subsequent hostility toward Connelly. Hyatt testified that she could not recall Connelly being particularly outspoken at the meeting, or any other incident where Connelly appeared to contradict or embarrass Trigilia. In light of the evidence regarding Trigilia’s animus toward Connelly, discussed below, I find it unnecessary to resolve this issue.

Lunch breaks and floor coverage were also a periodic concern for the RTs. RTs were required to punch out during their lunch period, which was unpaid. However, if they retained their beeper during their lunch period, they could not leave the facility and had to respond to calls regarding patients. This issue was discussed at a March 21 meeting, with Connelly asserting that the current practice violated Labor Department regulations. Connelly also discussed this issue directly with Harper. The policy was then clarified at a meeting on April 11, 2011, after Connelly's discharge, to provide that RTs who left the building for their lunch break would punch out and give their beeper to a co-worker.

There was also a continuing issue in the RT Department regarding the RTs' seniority. In particular, one employee, Sophie Zeil, had been an RT for a number of years and then retired, but was later rehired as a helper on the day shift, from 6 a.m. to 2 p.m. Harper testified that Respondent's policy regarding seniority required that Zeil's previous service be credited after she returned from retirement. Although only Connelly was actually denied a vacation period she requested because she had less seniority than Zeil, Slowenski and Hutson testified that this issue also affected the other RTs, because vacation scheduling was determined by seniority order. Connelly spoke about this issue at meetings, and raised it with Trigilia. The minutes of the April 5, 2011 RT department meeting indicate that vacation scheduling was still an issue for the RTs at that time.

D. Trigilia's Management of the Respiratory Therapy Department and Evidence of Animus toward Connelly

It is evident from the record that a significant amount of tension existed in the RT Department between management, specifically Trigilia, and the employees. Connelly, Hutson, and Slowenski all testified that they perceived Trigilia as duplicitous, and that, in their opinion, he did not interact with the RTs in a straightforward manner. Slowenski and Connelly testified that Trigilia yelled at them in meetings after they raised issues regarding staffing and, in Slowenski's case, receiving compensation for precepting other employees. In a December 6, 2010 series of Recommendations for action to be taken following the Connecticut Department of Public Health's investigation, discussed in further detail below, Hyatt identified several problems involving Trigilia's interactions with the RT staff. Specifically, Hyatt stated that Trigilia did not take "responsibility for the performance of the department including staff behavior," and "Tends to deflect responsibility and re-direct issues brought to his attention." Hyatt also noted that the RTs "don't feel safe bringing issues to management," and stated that she intended to meet directly with the RT staff to "Explore lack of trust/fear of retaliation issues," and "get to the root of" the Department's problems. Hyatt's Recommendations also state that Harper would encourage the RT staff to raise issues with him directly. A Performance Improvement Plan ("PIP") Hyatt imposed upon Trigilia the next month required that he take responsibility for decision-making in the Department, as opposed to deflecting or redirecting issues and blaming others, enhance his listening skills in his interactions with staff, and communicate expectations in a clearer and more direct manner. The PIP also required that Trigilia schedule the RTs "according to policy and fairly," and increase planning to ensure adequate staffing. The PIP stated that Hyatt would be assessing Trigilia's interaction with the RTs by meeting with them directly on a weekly basis.

Whatever the relationship between Trigilia and Connelly prior to the imposition of the PIP,⁶ after it was issued Trigilia focused on Connelly as a potential problem for him. Burke

⁶ At the hearing, Connelly testified at length regarding her activities, and Trigilia's retaliatory responses, during the period between the fall 2009 meeting (when she purportedly

Continued

testified that when he was applying for the position of RT Supervisor in late January or early February 2011, Trigilia told him to watch out for Connelly, Charland, and Kim Sadler,⁷ another RT. Trigilia told Burke that Connelly was “a loudmouth, always running her mouth and giving him a hard time.” Trigilia advised Burke to handle such employees “with kid gloves,” and “watch your back.” Burke testified that in other conversations with Trigilia after applying for the supervisory position, Trigilia told him again that Connelly was “a big troublemaker...always running her mouth off and looking to cause issues in the department.” These conversations took place in the break room during lunch, and in the hallway of the Luscomb building after an RT Department meeting. Burke was promoted into the supervisory position, and immediately afterwards Trigilia told him to “be careful of Jeanine, don’t trust her,” again referring to Connelly as a “troublemaker” and a “loudmouth.”⁸ This conversation took place in the hallway outside of the RT Department. Charland also testified that after the PIP was issued, Trigilia told her in the hallway of the Lyman building that Connelly was very vocal, and “was going to be the death of him.”

In addition, in the fall of 2011, Hutson left a Subpoena *Ad Testificandum* issued to him by the General Counsel in Burke’s mailbox, so that Burke would be aware that he needed time off of work to attend the hearing. Burke, who was still the RT Department Supervisor at the time, told Hutson that, “you shouldn’t be talking about this,” because “Administration’s going to be upset with you.” Burke testified that he made these statements to Hutson because he was concerned that Schlette (then the Director of the RT Department), Hyatt, and Harper “would take it the wrong way,” and that Hutson might be “in trouble” as a result. Burke testified that he held this opinion based upon his experiences while employed at other health care facilities, and not with Respondent.

E. The Investigation by the Connecticut Department of Public Health and Gaylord’s Response

In November 2010, the Connecticut Department of Public Health (“DPH”) visited _____ embarrassed him in front of Hyatt) and the fall 2010 DPH investigation. In brief, Connelly contends that during this period of time Trigilia threatened to discharge her on multiple occasions, threatened to discipline her, did not allow her to assist other RTs with patients and did not allow other RTs to assist her, did not allow her to speak with Teba, and denied her request for additional vacation time in conjunction with a medical leave. Trigilia stated that he did not recall these incidents, with the exception of the denial of additional vacation time. Slowenski testified that Trigilia would periodically announce his intention to discharge a particular RT, but the actual termination never took place. In light of the evidence regarding Connelly’s activities and Trigilia’s statements to Burke and Charland in early 2011, discussed below, I find it unnecessary to delve into the evidence regarding Connelly and Trigilia’s interactions prior to that time.

⁷ Trigilia was apparently under the impression that Sadler and Charland had reported the incident involving Donna Ward, discussed below, to the DPH.

⁸ I credit Burke’s testimony regarding these conversations. The sentiments Trigilia expressed to him are consistent with those he articulated to Charland, with the testimony of Slowenski regarding Trigilia’s attitude toward Connelly, and with evidence establishing Trigilia’s generally poor relationship with the RTs, as evinced in his PIP. Indeed, it should be noted that when questioned at the hearing regarding this statement Trigilia responded that he never made it, “because I would have felt that about everybody.” Hutson, Burke, Hyatt, and Harper all testified that a number of RTs were quite vocal regarding the various issues which arose in the RT Department, and that Connelly was not unusual in this regard.

Respondent's facility for at least three days to investigate specific issues which had been raised with them, and then conducted an exit interview with Respondent's administrators on or about November 10, 2010. After the exit interview, Respondent's managers began investigating the specific incidents the DPH identified, and formulating responses to the problems raised. On
5 February 10, 2011, the DPH issued a report finding several violations in the RT Department of pertinent regulations and statutes. One specific incident involved an RT (David Girman) who "was alleged to tap [a] patient on the nose and forehead with a large vial of normal saline." Another involved Supervisor Donna Ward, who allegedly retrieved an inner cannula from the trash and handed it to a doctor to insert into the patient during a tracheostomy tube change.
10 The DPH found that the first of these incidents was reported to the Director of Nursing and to Trigilia, neither of whom took any action. The second incident was not reported to Respondent's management. Hyatt and Hostage both testified that no occurrence reports had been prepared regarding these incidents, and that Respondent had no knowledge of them prior to the DPH investigation.

15 In addition to the specific incidents discussed above, the DPH identified three other issues involving the RT Department. The DPH identified a recurrent problem with missed medications, i.e., medications which were prescribed for specific patients but not administered as directed. The DPH also concluded that Respondent failed to ensure that RT Department
20 staffing was adequate to meet the requirements of five patients. Finally, the DPH found that Respondent had failed to revise its performance improvement plan after data indicated that there were compliance problems with missed respiratory therapy medications.

25 In response to the issues identified by the DPH in its exit interview, Respondent's management began investigating the incidents and concerns raised, preparing reports, and formulating methods for addressing the various problems. Although Hostage investigated the incidents and addressed regulatory compliance matters, ultimately Hyatt determined what specific disciplinary action would be appropriate. With respect to the incident involving RT David Girman, Hostage interviewed the individuals involved and prepared a report including
30 recommendations. Hyatt concluded that the results of the investigation did not establish that Girman physically hit the patient as alleged, but did demonstrate that he spoke in a loud, angry voice. As a result, Girman was issued a written warning on December 10, 2010, and the Nursing Supervisor and Director of Nursing were disciplined for failing to ensure that the incident was properly documented and investigated.⁹ Hostage also interviewed the individuals
35 involved in the tracheostomy tube change incident, and Hyatt discharged Ward on December 9, 2010 as a result, over Trigilia's objection.

40 After considering the missed medications issue, Hostage and Hyatt concluded that the problem was systemic in nature, and was not attributable any one or more particular RTs. Respondent's management therefore embarked on an effort to provide education to the RTs as a group, and to improve their practice with respect to missed medications. To do so, Respondent altered its policy so that "Patient Sleeping" and "Deferred" were eliminated as acceptable reasons for missed medications. Respondent also sought to increase the RTs' filing of occurrence reports for missed medications. Hostage testified that there are several different
45 types of occurrence reports – a general occurrence report, and specific occurrence reports for medications, falls, and skin issues. Hostage stated that she received fewer occurrence reports from the RT department than she would expect. Following the DPH findings regarding missed

50 ⁹ The Nursing Supervisor and Director of Nursing were issued written warnings, and the Director of Nursing was also placed on a Performance Improvement Plan. Girman later resigned.

medications, Hyatt and Hostage were specifically interested in increasing the number of medication occurrence reports filed by RTs.

5 Finally, as a result of all of the problems identified in the RT Department, on February 3, 2011 Trigilia was placed on the PIP discussed previously. As part of the PIP, Hyatt gave Trigilia thirty days to effect a “clear turnaround,” or face possible discharge.¹⁰

10 As part of its efforts to educate the RTs regarding missed medications and filing occurrence reports, Hyatt began attending more weekly meetings of the RT Department. The DPH’s findings regarding missed medications were first discussed at the November 17, 2010 meeting, with Trigilia informing the staff that everything must be documented, and that the reason for the missed medication or treatment in question must be clear. Subsequently, missed medications were discussed at the February 16, 2011 and March 28, 2011 meetings, the second of which Hyatt attended. The minutes of the March 28, 2011 meeting state as follows:

15 4. Revising 6-2:30 Responsibilities:

[subparagraphs a through c omitted]

d. Occurrence reports must be done on all missed treatments and lack of documentation.

20 e. Forms will be put in the department. Once they are filled out give them to Mike as he and Paul to give to Pharmacy. Paul and Mike will be tracking this information.

25 The record establishes that there was initially considerable confusion among the RTs as to the nature of the occurrence reports. Connelly and other RTs were concerned that the occurrence reports which Respondent was now encouraging them to complete regarding missed medications would somehow result in discipline, so that the RTs would in effect be “writing each other up” in the course of documenting missed medications. Connelly believed that the occurrence reports the RTs were being asked to fill out were not medication occurrence reports, but another type of occurrence report which could lead to discipline or discharge. A 30 March 31, 2011 e-mail from Harper to Hyatt refers to a “considerable stir surrounding the new RT requirement that staff report staff.” Hyatt in reply stated that existing policy required the completion of an incident report when an RT discovers that a treatment has not been administered. Harper responded that he “could tell from the reaction by some that this 35 appeared to be new and [they] had questions about it and concerns.” As a result, Hyatt and Hostage both attended RT Department meetings on April 5 and 11, 2011 to discuss the nature and purpose of occurrence reporting for missed medications.

40 F. Connelly’s Confrontation with Burke on March 31, 2011

Although Connelly did not attend the March 28, 2011¹¹ meeting, other RTs discussed it with her during the days that followed. According to Charland, she and Connelly, as well as Slowenski and Maher, discussed the increased emphasis on occurrence reports while working together. Charland stated that all of the RTs were apprehensive because of the increased focus 45 on the RT Department and missed medications in the wake of the DPH investigation. Charland testified that Connelly in particular was concerned that the number of missed medications could lead to “a lot of trouble with the state,” and that the problem had to be corrected. Charland,

50 ¹⁰ Hyatt stated that Trigilia made significant improvement during the first thirty days of the PIP. Trigilia eventually left Respondent’s employ of his own accord in June 2011.

¹¹ All subsequent dates are in 2011 unless otherwise indicated.

Slowenski, Maher, and Connelly were all concerned that completing occurrence reports for missed medications would in fact constitute issuing one another written warnings. According to Charland, the RTs felt that further discussion with management was necessary to determine whether increased occurrence reporting was the best method for addressing the missed medications problem.

On March 31, Connelly arrived to begin her shift at 7:00 a.m., and went to the RT Department Documentation Room. She retrieved her paperwork, and while writing out her assignment she noticed the minutes of the March 28 RT Department meeting posted on the bulletin board. When she read “Occurrence reports must be done on all missed treatments and lack of documentation,” she became upset, believing as she did that such occurrence reports involved the RTs’ writing one another up. She mentioned the occurrence reports to Hutson and RT Helena Egolum, who were also present in the room. Hutson and Egolum were also concerned about requiring the RTs to report one another’s mistakes, which was what all three apparently believed was being mandated. After reading that “Mike [Burke] will be tracking this information,” Connelly decided to speak with him. Before doing so, however, she looked in her mailbox, which contained a form indicating that her request for vacation time had been denied because another RT with more seniority had requested permission to take vacation during the same period.¹²

Connelly then went to Burke’s office, and stood in the doorway while speaking to him. Connelly told Burke that she was concerned for the RTs, given the requirement that they complete occurrence reports for missed medications discussed at the March 28 meeting. Connelly told Burke that the occurrence reports were going to cause turmoil in the RT Department, because the RTs would in effect be writing one another up. Connelly told Burke that this was not the direction the Department should be taking. Burke attempted to explain to Connelly that the RTs would not be writing one another up by completing missed medication occurrence reports, and contended that the emphasis on occurrence reports was not his fault. Connelly testified that she responded that it was just going to cause more trouble, and Burke testified that Connelly also told him that he was “trouble.” Burke reiterated that the occurrence report requirement had nothing to do with him, and Connelly stated that he was involved because, according to the minutes, the reports had to be submitted to him. Burke said that Hyatt was responsible. Connelly began raising her voice during this discussion, and Burke raised his voice as well in response. Connelly then began discussing the denial of her vacation request, saying that Sophie Zeil should not have more seniority than she did, because Zeil had retired. Burke tried to explain that he had consulted with Human Resources, which had provided him with a seniority list. After reviewing the list and consulting with Trigilia, Trigilia determined that Zeil had more seniority, and that as a result Connelly’s vacation request should be denied. Finally, Egolum approached the office, and told Connelly that they should begin their work, so that Connelly would not get in trouble. Connelly and Egolum then left the doorway of Burke’s office. The entire discussion between Burke and Connelly lasted for about three to four minutes.

Burke’s office is in a small suite of offices off a corridor, which also contains the RT break room, the food and nutrition supervisor’s office, the blood gas lab, the RT administrative office, the RT Documentation Room, the inpatient therapy supervisor’s office, and a physician’s office. Although the inpatient therapy supervisor sometimes sees patients in their office, the suite of offices is not a patient care area, and there were no patients present at the time of

¹² Connelly understood this to be Sophie Zeil, who had additional seniority from her previous full-time employment with Respondent, as discussed above.

Burke and Connelly’s discussion. During the discussion, someone may have closed the door of the physician’s office next door to Burke.

At 7:40 a.m., Burke sent the following e-mail to Trigilia:

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Paul at 720 this morning Jeanine came to my door at my office questioning some of the minutes from Mondays minutes. In discussing about miss[ed] tx’s¹³ and writing occurrence reports. She disagreed with writing these on fellow therapist which is fine she is allowed her thoughts. The[n] she started to get verbally abusive with me screaming at me that I am TROUBLE by making people do this. I tried to explain that it came from upper management and she continued to get loud with me. Helena heard it from the staff documentation room and came in and grabbed Jeanine to pull her away. Consider this a write up I will not tolerate this attitude and she is continually walking around here bad mouthing myself as I write this.

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G.C. Ex. 29 (emphasis in original).

G. Connelly’s Error in Performing an Arterial Blood Gas Analysis on April 1

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On April 1, Connelly arrived at the facility at 7 a.m., and was assigned to work on the second floor of the Milne building. When Connelly checked the bin for ABG tests she noticed that there were three such tests which needed to be run.¹⁴ Prior to running these tests Connelly spoke to Gerstenhaber, who was dictating at a computer at the Milne 2 nurses’ station, regarding one of the patients, and explained that the results of their ABG tests would be late because she was falling behind and in a rush. Gerstenhaber explained that he had to be at a meeting in ten minutes, and didn’t have much time. One of the ABG tests had been ordered by Gerstenhaber to be performed on April 5, and not on April 1. However, Connelly performed the test ordered for April 5 on April 1, the day Gerstenhaber entered the order, instead. When Connelly was putting together the paperwork after the test had been performed, she noticed that she had run the test on the wrong day. Connelly stated during her testimony that although she was busy with patients that needed attention that particular morning, the mistake was her fault, because she did not pay careful enough attention to the dates on Gerstenhaber’s order.¹⁵

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Connelly then went to report the ABG results to Gerstenhaber, and explain that she had performed the test on the wrong day. Connelly spoke to Gerstenhaber at the nurses’ station on Milne 2, where he was still dictating.¹⁶ Connelly testified that she told Gerstenhaber that although he had ordered the test for April 5 she had run it that day. Connelly asked Gerstenhaber whether he still wanted an ABG test run on the patient on April 5, and

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¹³ “Tx’s” is intended to mean “treatments.”

¹⁴ Normally these tests would have been run by the helper on the 6 a.m. to 2 p.m. shift, but the helper was covering for another RT who was coming in late. Connelly was also delayed in running the test by the need to stabilize additional patients on her floor. None of the ABG tests ordered involved a medical emergency.

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¹⁵ The parties stipulated at the hearing that Connelly’s error in performing the ABG test on April 1, as opposed to April 5, had no adverse impact on the care or condition of the patient.

¹⁶ Hyatt testified that this is not the appropriate procedure for reporting the results of an ABG test. Hyatt testified that the RT should instead call or page the physician from the ABG lab, report the results over the phone, and immediately enter the identity of the physician to whom the results were reported into the Meditech system.

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Gerstenhaber said that he did. They proceeded to review the results of the ABG test and discuss the patient's condition. Connelly then asked Gerstenhaber whether he could put in an order for the April 1 ABG test that she had just performed. According to Connelly, Gerstenhaber said that he didn't have time because he was leaving. Connelly testified that she then asked whether Gerstenhaber wanted her to put a verbal order in for the test, and Gerstenhaber said OK.

Gerstenhaber testified that he recalled Connelly telling him on April 1 that she had inadvertently run an ABG test which he had ordered for April 5 on the morning of April 1 instead. Gerstenhaber testified that he recalled Connelly then reporting the results of the ABG analysis to him. Gerstenhaber could not recall whether the conversation took place over the phone or in person. In his affidavit, Gerstenhaber stated that he did not recall anything else about their conversation, and in his testimony Gerstenhaber stated that he specifically did not recall Connelly asking him to enter an order covering the ABG test mistakenly run on April 1, or Connelly asking his permission to enter a verbal order covering the test.¹⁷ Gerstenhaber testified that he believes that verbal orders are highly susceptible to misinterpretation and cause confusion, and that as a result he had never given permission for a verbal order in a non-emergent situation.¹⁸ This is consonant with Respondent's policy, as articulated by Teba, that verbal orders are appropriate in emergency situations only.¹⁹ As a result, Gerstenhaber testified that it was "extremely unlikely" that he gave Connelly permission to enter a verbal order on April 1 to cover the ABG test that Connelly inadvertently performed that day.

At 8:12 a.m., after her discussion with Gerstenhaber, Connelly entered a verbal order for the April 1 ABG test whose results she had just reported to Gerstenhaber into the Meditech system, using the order entry module. However, Connelly entered the verbal order as an order given to her by, and read back to, Dr. Sadia Abbasi. I find, for the reasons discussed in Section III(C)(3), *infra*, that Connelly entered intentionally entered Abbasi's name into the Meditech system when entering the verbal order for the ABG mistakenly performed on April 1.

On April 1, at 3:50 p.m., Susan Fanning of Respondent's Medical Services sent an e-mail to Abbasi and Trigilia, among others, indicating that there was an unsigned verbal order in Abbasi's sign queue entered by Connelly for the ABG test she mistakenly performed that morning. Fanning asked Trigilia to investigate.

H. The Written Warning Issued to Connelly on April 1, Based Upon her Confrontation with Burke the Previous Day

After receiving Burke's e-mail on the morning of March 31 regarding the confrontation

¹⁷ Gerstenhaber testified that because the medical group to which he belongs was contractually obligated to provide four hours of service a day, he typically did not leave Respondent's facility until 10 a.m. Respondent introduced evidence at the hearing that Gerstenhaber's last patient note on April 1 was entered at 9:51 a.m. Gerstenhaber was adamant during his testimony that although it is technologically possible to enter such patient notes from another location, he does not do so, because he prefers to enter notes immediately after seeing the particular patient.

¹⁸ As discussed in Section III(A), *infra*, the weight of the credible evidence does not establish that Gerstenhaber gave verbal orders between December 6, 2010 and Connelly's discharge.

¹⁹ As discussed in Section III(A), the preponderance of the credible evidence establishes that verbal orders were rarely given outside of emergency situations such as codes.

with Connelly, Trigilia began investigating the incident. Trigilia spoke to Burke, who explained what had happened. Trigilia told Burke that they were going to have to issue a write-up to Connelly, at one point mentioning that the incident might be grounds for discharge, although he didn't believe that would come about. Burke testified that he felt that some sort of discipline was
5 necessary, and recommended that Connelly be issued a verbal warning. Trigilia felt that a written warning would be more appropriate because Connelly had been insubordinate, but did not mention Connelly's outspokenness. Burke testified that the discussion centered on Connelly's behavior and manner of addressing him. In the course of investigating the incident, Trigilia also spoke to Egolum.

10 In the early afternoon of March 31, Trigilia and Burke met with Connelly in Burke's office. Trigilia discussed the incident, telling Connelly that she had been yelling at Burke, which constituted insubordination. He told Connelly that she would probably be receiving a written warning. According to Connelly, she then raised the issue of occurrence reports, and said that
15 the RTs were unhappy with being required to complete them. Trigilia explained in response that medication occurrence reports were at issue, and they discussed the possibility of receiving notification from the Pharmacy Department when missed medications occurred. Connelly then left the office to return to work.

20 Subsequently Trigilia and Hyatt met to discuss the incident and the appropriate discipline. Hyatt was concerned because Burke was new to the supervisory position, and believed that Connelly had spoken to him in a loud and inappropriate manner in a relatively open area. Hyatt agreed that a written warning was appropriate. Trigilia and Hyatt then composed a written warning together, which states as follows:

25 I have completed my investigation of what occurred this morning between you and Michael Burke in the respiratory staff area. Mike reported that you were screaming at him and said "you are trouble." This has been corroborated by a witness. Speaking to a supervisor in this manner is disrespectful, insubordinate
30 and will not be tolerated.

The warning also states that if the behavior occurs again, further disciplinary action up to and including termination may be imposed.

35 On April 1, Trigilia and Burke met with Connelly to issue the written warning to her. Burke called Connelly while she was working, and while on her way to Burke's office, Connelly asked Slowenski to accompany her as a witness. When they arrived, Trigilia told Connelly she was being given a written warning for insubordination because she had screamed at Burke. Trigilia asked Connelly to sign the written warning, and Connelly refused to do so, because she
40 believed it to be inaccurate. Connelly then told everyone that she was going to Human Resources, and left.

45 Connelly proceeded to the office of Employment Administrator Bryana Minor, in Human Resources. Connelly and Minor discussed both the written warning and the occurrence reports issue. Connelly told Minor that she felt the written warning was inaccurate, and that management had skipped several steps in the disciplinary process. Connelly also stated that in her opinion Burke should have been disciplined as well, because he had also raised his voice. Connelly then told Minor that during her confrontation with Burke she had been addressing the occurrence reports and the turmoil she felt that they would cause in the department. Minor
50 explained that the medication occurrence reports were not intended to be used for disciplinary purposes, but only to obtain accurate information and to allow situations to be addressed in a timely manner. Minor suggested that Trigilia and Burke be called into the meeting, so that they

could address the issues together and move forward.

Trigilia and Burke arrived, and the discussion continued. Connelly reiterated her concerns regarding the occurrence reports, and Minor asked Trigilia to explain the issue from a clinical and departmental perspective. Connelly stated that she felt the write-up was not fair, because Burke had raised his voice as well and was not receiving any discipline. Burke said that he had in fact raised his voice, but only to attempt to get Connelly's attention because Connelly was not listening to him. Trigilia said that Connelly was still being written up. At that point, Minor said that because it was getting late in the day the participants should take a break and reconvene on Monday to continue the discussion. Before ending the meeting, Minor told Trigilia, Burke, and Connelly that they should keep the discussion to themselves for now, and resume the conversation on Monday. After the meeting Connelly was still upset, and either Burke or Trigilia told her that she should go home for the day.

I. Respondent's Investigation Regarding the Documentation of Connelly's April 1 Error, and Connelly's Suspension and Discharge

On the morning of April 4, Trigilia visited Burke in his office, and said he had received an e-mail from Abbasi that there was a verbal order in her sign queue from a day that she had not been working.²⁰ Trigilia asked Burke to investigate and determine who had created the verbal order, and under what circumstances. Hyatt also recalls Trigilia calling her that morning and informing her of the issue. Hyatt believed that Burke was investigating as a result.

Burke went to the blood gas laboratory and reviewed its records to determine what blood gas was run and who signed it. He then ran the order trail as well, which revealed Connelly's name. When he brought this information to Trigilia, Trigilia asked him to speak to Connelly about it. Burke approached Connelly, and asked her what happened and why a verbal order was entered under Abbasi's name. Connelly stated that she had tried to put the order into the Meditech system under Gerstenhaber's name, but the system did not allow her to do so, and Abbasi's was the name that came up.²¹ Connelly explained that she did not change Abbasi's name after it came up in the system because Abbasi was the attending physician on the floor that day.²² Connelly said that she was aware that Abbasi, as opposed to Gerstanhaber, ended up as the physician on the verbal order. Burke asked Connelly why she did not come and discuss the matter with him at the time, to see if they could correct the problem. In Burke's affidavit provided during the investigation he stated that Connelly did not respond to this question, but at the hearing Burke testified that Connelly responded that she was busy, and Burke informed her that that was not an acceptable excuse.

²⁰ The following account is based in large part upon the testimony of Hyatt and Burke. As discussed in Sections III(A) and (C), below, of the witnesses directly involved in Respondent's investigation of the April 1 verbal order for the ABG test, I find the testimony of Hyatt and Burke most reliable, with certain exceptions in Burke's case discussed below. Trigilia had a generally poor memory of these events, and Harper was only peripherally involved.

²¹ Burke initially testified that Connelly told him that the Meditech system "defaulted" to Abbasi's name. Later, Burke testified that Connelly did not use the word "default," and that he surmised on his own that Abbasi's name was the "default name" because she was the attending for that particular patient. Burke later stated that his testimony regarding a "default" to Abbasi's name was based on a meeting months after Connelly's discharge with Susca, who purportedly informed those attending that a "glitch" in the Meditech system could result in a "default" to Abbasi's name.

²² In fact, Abbasi was not the attending for Milne 2 on April 1.

Burke then reported his conversation with Connelly to Trigilia. Trigilia responded that Connelly had intentionally falsified a medical record, and that disciplinary action, possibly termination, was necessary. Burke testified that at this point he believed that although Connelly was aware that the verbal order was entered under an incorrect physician name, she had not intentionally falsified a medical record. Trigilia and Burke then met with Hyatt and explained what they had discovered up to that point. Hyatt directed them to speak with Gerstenhaber, and attempt to determine what had happened. There was no recommendation or discussion of discipline to be imposed at this meeting.

At some point Trigilia also spoke with Abbasi, who told him that she would not sign off on the ABG test, because she had not ordered it and had not been given the results. The April 1 order therefore remained unsigned.²³

Burke then went to discuss the ABG test with Gerstenhaber. Apparently he first approached Connelly and told her that he was going to be speaking with Gerstenhaber. Connelly told him that she wanted to speak with Gerstenhaber as well. They located Gerstenhaber, and went into the documentation room on Milne 2. Connelly began the conversation, and asked Gerstenhaber whether he remembered giving her a verbal order the past Friday for a blood gas that was run on the wrong day. Gerstenhaber responded, "I'll cover for you this time, but don't let it happen again."²⁴ Gerstenhaber testified that at the time he made this statement he was not aware that there was already an order in the Meditech system for the April 1 ABG under Abbasi's name. Gerstenhaber testified that he assumed at the time that no order for the April 1 ABG test had been entered into the system. He testified that by his statement, "I'll cover for you this time, but don't let it happen again," he meant that he was willing to have an order placed in the system under his name to cover the April 1 ABG test. Gerstenhaber testified that he would not have offered to do so had he known that there was already a verbal order in the system under another physician's name.

Burke and Trigilia then met with Hyatt to discuss the new information they had discovered. Trigilia reported to Hyatt that Connelly had put the order into Meditech under Abbasi's name because Abbasi was the attending physician. Hyatt asked Trigilia how difficult it would have been to retrieve Gerstenhaber's name in the system, and Trigilia said that if the letter "G" were typed in, all of the doctors whose names began with "G" would come up. In addition, the RT could always seek assistance from a supervisor or co-worker. Trigilia also related Burke's conversation with Gerstenhaber, wherein Gerstenhaber stated, "I'll cover for you this time, but don't let it happen again," and they discussed whether Gerstenhaber had in fact given Connelly a verbal order on April 1. Hyatt believed that if Gerstenhaber had actually given the verbal order on April 1 he would have explicitly said as much. She concluded that Gerstenhaber meant that he was willing to put in a retroactive order covering the April 1 ABG test at that time, but had not given the verbal order to do so on April 1.

Hyatt and Trigilia believed that Connelly's conduct constituted falsification of a medical record and was a very serious offense, because the order was entered under the name of a physician who had not authorized it and had no knowledge of it. Hyatt directed Trigilia to determine whether any additional investigation needed to be conducted, and they decided to

²³ The order was never signed, and Respondent eventually voided any charges for the ABG test.

²⁴ For the reasons discussed in Section III(C), I find that Gerstenhaber did not tell Burke and Connelly that he remembered giving Connelly the verbal order on April 1.

suspend Connelly. Hyatt also wanted time to consult with Human Resources regarding the matter. Hyatt could not recall whether she made any recommendation at the meeting as to what discipline would ultimately be appropriate. She testified that Trigilia recommended that Connelly be discharged. According to Hyatt, Burke did not do anything to indicate disagreement during this meeting.

For the reasons discussed in Section III(C), *infra*, I do not credit Burke's testimony that he informed Trigilia prior to meeting with Hyatt that, in his opinion, Gerstenhaber had in fact given Connelly a verbal order on April 1 for the ABG test Connelly had performed on the wrong day. I also do not credit Burke's testimony that he informed Hyatt, or anyone else in Respondent's management, that he believed that Gerstenhaber had given Connelly the verbal order on April 1, prior to leaving his employment with Respondent in December.

Trigilia and Burke then met with Connelly to inform her that she was being suspended. Trigilia asked Connelly whether she had put a blood gas under Abbasi's name, and Connelly asked Burke whether they were talking about the ABG test they had just discussed with Gerstenhaber. Burke did not respond, and Trigilia said that Connelly was being suspended pending further investigation of the incident. Trigilia said that he would call Connelly and let her know the final outcome of the investigation. Connelly asked about her patients and retrieving her belongings, and Trigilia said that Burke and a security guard would escort her to the floor so she could pick up her things. While walking Connelly out of the building, Burke told her not to worry, because she had Gerstenhaber on her side. Burke testified that he said this based upon Gerstenhaber's statement, "I'll cover for you this time," because he wanted to make Connelly feel better about the situation.

During the afternoon of April 4, Connelly saw Harper in Milne 2 and asked to speak with him; Harper suggested that she come to his office at 5 p.m. Connelly testified that she discussed her confrontation with Burke regarding the occurrence reports, contending that she had not been screaming and that the warning was inaccurate. According to Connelly, Harper responded that he had heard about what was going on in the RT Department. Harper said that in the future there would only be a positive work environment, and that complainers would have to go. Harper testified that Connelly complained about the warning she had received regarding the confrontation with Burke, arguing that although she had been loud with Burke, Burke had raised his voice toward her as well. Harper testified that he tried to explain that Connelly and Burke were in different positions, and that yelling at a supervisor was not appropriate. Connelly also expressed her concerns regarding the occurrence reports. Harper testified that he suggested that she speak to Burke and Trigilia, and attempt to move past the confrontation to develop more productive working relationships.

During the next several days, Hyatt, Trigilia, and Burke continued to discuss the incident.²⁵ Trigilia reviewed the audit trail again, discussed the matter with Hyatt, and, together with Harper, drafted and edited a letter to Connelly discharging her. Hyatt testified that she made the ultimate decision to discharge Connelly, and believed that discharge was appropriate because Connelly entered a verbal order into the system from a doctor that she had never spoken to and did not in fact have an order from. Given the information available at the time, Hyatt believed that Connelly was attempting to cover up having entered the order under the name of a physician that had not given it, and possibly also the fact that she had performed the ABG test on the wrong day. Trigilia testified that he believed discharge was appropriate for a

²⁵ On April 6, Connelly spoke to Gerstenhaber. Gerstenhaber told Connelly that he had spoken with Trigilia, and that Connelly had committed a very serious offense.

number of reasons, including the fact that the ABG test was an invasive procedure and the entering of the verbal order under the name of a physician who had not given it. Respondent's termination statement, which incorporates Burke's activities during the investigation, states as follows:

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It was reported to me that you entered a "verbal order" on 4/1/11 without the approval of the doctor. When I looked into this, I found that you had performed a clinical procedure (Arterial Blood Gas) on the wrong day, not in concert with the written MD directive. When I asked you about this you admitted to performing the procedure on the wrong day. When I asked you why you entered the verbal order for the wrong day using a different doctor, you said it was because her name was the first to come up. During a follow up conversation with you, your supervisor Mike Burke, and me, you admitted that you entered the "verbal order" order without authorization from a doctor. I told you that this was a serious breach of protocol and you were suspended pending further investigation.

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My further investigation confirmed my earlier findings. The physician has confirmed that she never spoke to you about this procedure and did not give a verbal or telephone order to you for this procedure. She was not even on duty at the time. Further, falsifying a medical record is an egregious breach of procedure. Not only does this put the patient at risk, but it also puts the hospital at risk. The "verbal order" entry requirement is a well established protocol that requires an actual verbal order from a physician.

25

Therefore, your employment with Gaylord is terminated effective April 8, 2010 [sic].

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Trigilia testified that he made several attempts to call Connelly during this time, in order to inform her that Respondent had decided to terminate her, but was unsuccessful until April 8. On that day, the termination statement was sent to Connelly, along with a letter containing her final paycheck and other information.

III. Analysis and Conclusions

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A. General Conclusions Involving Witness Credibility

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I found the Charging Party, Jeanine Connelly, to be a generally credible witness with respect to many of the specific events leading to her written warning on April 1 and her suspension and discharge on April 5 and 8, respectively. However, I also found that she exhibited a propensity for exaggeration, and for making assertions of fact regarding matters of which she knew little. Perhaps most importantly, Connelly gave several contradictory explanations regarding the manner in which Abbasi's name appeared on the verbal order for the April 1 ABG that she entered, regardless of her purported lack of understanding of the Meditech system itself. Of course, Connelly is an RT, and not an information technology specialist, and eventually she admitted that she had no idea how Abbasi's name ended up on the verbal order. But I find her willingness to make repeated assertions regarding issues about which she knew little, regardless of their importance, revealing in assessing the reliability of her testimony.

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Connelly thus engaged in conjecture regarding practices at the hospital which was contradicted by more reliable evidence. For example, Connelly testified that Gerstenhaber had given her "some" verbal orders between December 6, 2010 and the time of her discharge, and had encouraged her to take verbal orders in general. However, an analysis of electronic data in

the Meditech system performed by Respondent established that Gerstenhaber issued no verbal orders at Respondent's facility during that time period.²⁶ In fact, the evidence establishes that verbal orders were strongly discouraged outside of emergency situations such as codes, and that verbal orders were rarely given. This policy was established by Teba, Respondent's Chief Medical Officer, and reiterated at RT Department meetings beginning on December 6, 2010. Respondent's analysis of electronic data established that from December 2010 through February 2012 only three verbal orders, including Connelly's April 1 order, were entered in the RT Department.²⁷ Burke, Hutson, and Slowenski all testified that they were aware of Respondent's policy that verbal orders were appropriate in emergencies only, and Hutson and Slowenski both testified that they would not take verbal orders in non-emergent situations.

Similarly, although Connelly claimed that running a test on the wrong day was a common mistake, none of the RTs currently employed by Respondent, or Burke, were able to recall specific examples of having done so. Indeed, Slowenski testified that she last made such a mistake in 2006, and Hyatt testified, based upon research performed by Switajewski, that tests had been run on the wrong day on only two occasions in the previous twelve months. Connelly also repeatedly asserted that occurrence reports involving issues other than missed medications were completed in triplicate, while Hyatt testified that Respondent had never used such forms. Connelly claimed that the opening of the Milne building coincided with a change in Respondent's licensure, which Hyatt more credibly testified had never occurred. Finally, Connelly was argumentative and unresponsive on cross-examination, and had to be directed by me to answer the questions posed to her on more than one occasion (Tr. 585, 587, 589).

I found RTs Teresa Charland, William Hutson, and Marlene Slowenski, all currently employed by Respondent, to be credible witnesses overall. It is well-settled that as current employees of Respondent, their testimony may be considered particularly reliable in that it is potentially adverse to their own pecuniary interests, as the Board has noted. *Covanta Bristol, Inc.*, 356 NLRB No. 46 at p. 8 (2010); *Flexsteel Industries*, 316 NLRB 745 (1995), *enfd*, 83 F.3d 419 (5th Cir. 1996). However, I found that they also made assertions regarding issues, such as mistakenly performing a test on the wrong day and entering an incorrect physician name, which were not borne out by their recollection of specific incidents, or by Respondent's investigations using its electronic record-keeping systems. As a result, I find these elements of their testimony less reliable.

I found Michael Burke to be a credible witness with respect to Trigilia's statements describing Connelly as a "loudmouth," a "troublemaker," and the like, and regarding much of Respondent's investigation into the verbal order for the April 1 ABG test. The specific exceptions where I found Burke's testimony to be less than credible are discussed in detail in Section III(C), below.

General Counsel argues that adverse inferences should be drawn based upon

²⁶ I do not find that the evidence establishes that Gerstenhaber gave Charland a verbal order on or about February 27, 2011, as the record is unclear as to whether or not the particular patient was on a protocol which would allow RTs to enter orders without a physician's involvement.

²⁷ I do not find the evidence regarding verbal orders placed by employees in Respondent's Nursing Department to be probative. The Nursing Department employees have different duties and a different line of supervision than the RTs, and there is no evidence regarding the verbal orders they might enter, or the specific circumstances which would be involved. In addition, the Nursing Department is almost ten times the size of the RT Department.

Respondent's failure to call Helena Egolum and Tracie Switajewski, who are currently employed by Respondent, as witnesses. I decline to do so. While an adverse inference may be drawn from the failure of an employer to call a current manager, supervisor, or agent, current employees cannot be considered predisposed to testify in one manner or another, and are equally available to both parties.²⁸ *Compare International Automated Machines, Inc.*, 285 NLRB 1122 (1987), *enfd*, 861 F.2d 720 (6th Cir. 1988), and *Torbitt & Castleman, Inc.*, 320 NLRB 907, 910, fn. 6 (1996), *enforced in relevant part*, 123 F.3d 899, 907 (Fed. Cir. 1997). There is no evidence in the record to establish that Egolum and Switajewski are managers, supervisors, or agents of Respondent, and adverse inferences are therefore not warranted.

With respect to Respondent's witnesses, I found Charlotte Hyatt to be generally credible. Hyatt was thoughtful and straightforward, even when responding to questions which could have elicited an answer more favorable to Respondent's case, and candidly admitted as much when information sought was beyond her knowledge. I found Walter Harper to be credible as well regarding his participation in the investigation and Connelly's discharge; as he testified, his role was primarily an advisory and consultative one. I also found Bryana Minor to be a generally straightforward and credible witness. On the other hand, I found Trigilia to be a less than reliable witness. His memory of the events of the investigation regarding the April 1 verbal order was generally poor, and I do not credit his assertion that he never complained about Connelly to Burke. I have generally viewed his testimony with skepticism unless confirmed by another witness, or unless I found another witness' testimony to the contrary incredible.

B. Respondent Violated Section 8(a)(1) by Issuing a Written Warning to Connelly on April 1, Based Upon Her March 31 Confrontation with Burke

1. Contentions of the Parties and the Applicability of *Atlantic Steel*

General Counsel and Respondent make various arguments regarding the appropriate standards for determining whether Connelly's April 1 written warning, based upon her discussion with Burke on March 31, violated Section 8(a)(1) of the Act, and in particular the applicability of the analysis articulated by the Board in *Atlantic Steel Co.*, 245 NLRB 814, 816 (1979). General Counsel argues that Respondent violated Section 8(a)(1) by issuing a written

²⁸ While in several cases an ALJ has drawn an adverse inference from an employer's failure to call a manager's secretary as a witness, I find those cases inapplicable. In *Pratt Towers, Inc.*, the secretary in question was the sole person that the discriminatee informed regarding the condition for which he was allegedly discharged, and in the case cited by the ALJ in support of drawing an adverse inference Respondent's owner, as opposed to an employee, was not called to testify. 338 NLRB 61, 98-99 (2002), *citing Bay Metal Cabinets, Inc.*, 302 NLRB 152, 157, 173 (1991), *enfd*, 940 F.2d 661 (6th Cir. 1991). In *Made 4 Film, Inc.*, the ALJ relied in drawing an adverse inference on *Desert Pines Golf Club*, but in that case the Board explicitly declined to rely upon the adverse inference drawn by the ALJ in affirming the ALJ's decision. 337 NLRB 1152, 1159 (2002), *citing Desert Pines Golf Club*, 334 NLRB 265, fn. 1 (2001). Finally, in *AC Electric*, the secretary not called to testify actually signed the Region's commerce questionnaire on behalf of Respondent, which contended that it was unaware that the questionnaire existed. 333 NLRB 987, 1000 (2001).

Villa Maria Nursing Home and *Food Lion*, cited by General Counsel, involved, respectively, a labor consultant retained by Respondent, and a member of the family owning the property from which the Charging Party union had been unlawfully excluded. *Villa Maria Nursing Home*, 335 NLRB 1345, 1345, n. 1, 1355 (2001), *enfd*, 49 Fed.Appx. 289 (11th Cir. 2002); *Food Lion*, 340 NLRB 602, 608, fn. 4 (1991). Both cases are therefore inapposite.

warning to Connelly on April 1 in retaliation for her protected concerted activity. General Counsel contends that the *Atlantic Steel* analysis is inapplicable, because the evidence establishes that Connelly did not scream at Burke or refer to him, as opposed to the medication occurrence reporting policy, as “trouble.” General Counsel further argues that even if the

5 *Atlantic Steel* analysis is appropriate, three of its four components support the conclusion that Connelly’s conduct did not lose the Act’s protection.

Respondent argues that the April 1 written warning was not unlawful. Respondent contends that the *Atlantic Steel* analysis is insufficient to encompass the situation at issue here, given that its workforce is not unionized, there is no organizing campaign involved, and Respondent operates a hospital, as opposed to an industrial facility such as a factory.

10 Respondent also argues that the *Atlantic Steel* analysis is typically applied only in cases involving discharge, as opposed to other forms of discipline. Respondent further contends that three of the four components of the *Atlantic Steel* test tend to establish that Connelly’s conduct

15 during her confrontation with Burke lost the protection of the Act.

I find that the *Atlantic Steel* analysis is appropriate here. As an initial matter, I find that Connelly was engaged in protected concerted activity when discussing the medication occurrence reports and seniority issue with Burke. An employee engages in protected

20 concerted activity when they “act with or on the authority of other employees,” and not solely on their own behalf. *Meyers Industries, Inc.*, 268 NLRB 493, 496 (1984) (“*Meyers I*”), *remanded sub nom. Prill v. NLRB*, 755 F.2d 941 (D.C. Cir. 1985), *on remand, Meyers Industries, Inc.*, 281 NLRB 882 (1986) (“*Meyers II*”), *enf’d sub nom. Prill v. NLRB*, 835 F.2d 1481 (D.C. Cir. 1981). Employee activity may be concerted where it arises out of prior group activity, where the

25 employee acts either formally or informally on behalf of the group, or when the employee solicits other employees to engage in group action. *The TM Group, Inc.*, 357 NLRB No. 98, at p. 14 (2011), *quoting Asheville School*, 347 NLRB 877 (2006). Discussions of discipline which enforces employer policies are protected. *See, e.g., Kiewit Power Constructors Co.*, 355 NLRB

30 No. 150, at p. 1-2 (2010), *enf’d*, 652 F.3d 22 (D.C. Cir. 2011).

Here, the medication occurrence reports issue was clearly of concern to the entire group of RTs. The evidence establishes that the RTs had discussed the occurrence reports and the extent to which they might result in discipline, amongst themselves, and were worried that completing the occurrence reports would constitute disciplining one another, or “writing each

35 other up.” Indeed, the RT staff’s concern regarding the medication reports, or, as Harper summarized, “the considerable stir surrounding the new RT requirement that staff report staff,” was sufficiently widespread that both Hyatt and Hostage eventually addressed this specific topic at several RT Department meetings. Connelly’s confrontation with Burke was immediately

40 engendered by her reading the minutes of the RT Department’s March 28 meeting regarding the occurrence reports. As a result, I find that Connelly was engaged in protected concerted activity during her March 31 discussion with Burke.

I also find that the *Atlantic Steel* analysis is appropriate, despite Respondent’s argument that Connelly’s discussion with Burke took place in the context of a non-unionized healthcare

45 facility with no organizing campaign. The Board has not limited the *Atlantic Steel* analysis to manufacturing entities, and has in previous cases applied the test in the context of healthcare facilities. *See, e.g., Beverly Health & Rehabilitation Services*, 346 NLRB 1319, 1322-1323 (2006) (applying *Atlantic Steel* to conduct occurring at a nursing home); *Lee’s Industries, Inc.*, 355 NLRB No. 206 (2010) (*Atlantic Steel* analysis applied to outburst by home health aide). Nor

50 is the *Atlantic Steel* analysis limited to unionized workplaces or traditional labor-management settings such as grievance meetings or collective bargaining negotiations. *See Plaza Auto Center*, 355 NLRB No. 85 (2010), *enf’d in relevant part*, 664 F.3d 286 (9th Cir. 2011) (outburst

by car salesman in non-unionized dealership); *Datwyler Rubber and Plastics*, 350 NLRB 669 (2007) (statements by employee in non-union automobile parts plant). Finally, there is no basis for applying the *Atlantic Steel* analysis solely in cases of discharge, as opposed to other forms of discipline.²⁹ See *Beverly Health & Rehabilitation Services*, 346 NLRB at 1322 (applying

5 *Atlantic Steel* to evaluate an argument resulting in a 3-day suspension).

The *Atlantic Steel* analysis requires the consideration of four factors in order to determine whether an employee's conduct during an otherwise protected discussion is sufficiently egregious to obviate the Act's protection: (i) the place of the discussion; (ii) the

10 discussion's subject matter; (iii) the nature of the outburst on the part of the employee; and (iv) whether the outburst was provoked by the employer's unfair labor practices. See, e.g., *Plaza Auto Center, Inc.*, 355 NLRB No. 85 at p. 2, citing *Atlantic Steel*, 245 NLRB at 816. The four *Atlantic Steel* criteria are intended to permit "some latitude for impulsive conduct by employees" during protected concerted activity, while acknowledging the employer's "legitimate need to

15 maintain order." *Plaza Auto Center, Inc.*, 355 NLRB No. 85 at p. 2. As the Board has stated, the protections of Section 7 must "take into account the realities of industrial life and the fact that disputes over wages, bonuses, and working conditions are among the disputes most likely to engender ill feelings and strong responses." *Consumers Power Company*, 282 NLRB 131, 132 (1986). Therefore, statements during otherwise protected activity lose the Act's protection only

20 where they are "so violent or of such serious character as to render the employee unfit for further service." *St. Margaret Mercy Healthcare Centers*, 350 NLRB 203, 204-205 (2007), *enfd*, 519 F.3d 373 (7th Cir. 2008), quoting *Dreis & Krump Mfg. v. NLRB*, 544 F.2d 320, 329 (7th Cir. 1976).

25 2. The *Atlantic Steel* Analysis

Evaluating the four *Atlantic Steel* factors, I find that the evidence establishes that Connelly's conduct during her confrontation with Burke remained protected by the Act. The first component of the *Atlantic Steel* analysis militates only slightly in favor of finding that Connelly's

30 conduct retained protection and the fourth component does not favor protection. However, I find that because the second and third factors strongly support the conclusion that her conduct remained protected, overall her activity retained its protected character.

The first component of the *Atlantic Steel* test requires a consideration of the location of the employee's outburst. I find that the evidence pertinent to this factor ultimately weighs

35 slightly in favor of a finding that Connelly's conduct remained protected. Connelly and Burke's confrontation took place during work time, and occurred in a suite of offices used for administrative work such as charting and morning report. Connelly initiated the confrontation, and thus its location was not determined by some act on Respondent's part.³⁰ See, e.g., *Kiewit*

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²⁹ I also reject General Counsel's argument that the application of *Atlantic Steel* is unnecessary because Connelly never screamed at Burke or called him "trouble." The evidence establishes that Connelly did raise her voice and use the word "trouble." I reject as incredible

45 Connelly's testimony that when she was issued the written warning regarding her confrontation with Burke, Trigilia told her that the warning was for "screaming and complaining." Burke testified that Connelly was never told that the warning encompassed "complaining," and the affidavit Connelly provided during the investigation does not state that she was told that the warning was being issued for this reason. I therefore find that Trigilia and Burke did not tell

50 Connelly during this meeting that her complaining was the subject of the written warning.

³⁰ In the cases cited by General Counsel, the location of the confrontation was ultimately determined by the employer's conduct in, for example, calling a meeting of employees and

Continued

5 *Power Constructors Co.*, 355 NLRB No. 150, at p. 2 (employer determined the location of
 intemperate remarks by distributing warnings in a work area during work time, and in front of
 other employees). Egolum and Hutson overheard the argument, so that the confrontation could
 have undermined workplace discipline and the authority of a supervisor. *DaimlerChrysler Corp.*,
 344 NLRB 1324, 1329 (2005). However, the evidence also establishes that the area was not a
 patient care area, and there is no evidence that the conversation was overheard by patients or
 visitors. *Beverly Health & Rehabilitation Services*, 346 NLRB at 1322, n. 20, 1323. In addition,
 the evidence establishes that during the confrontation Egolum approached Connelly, suggested
 that they begin working, and guided her out of the area, not a course of events which indicates
 10 that her respect for Burke’s supervisory position had been derogated by Connelly’s outburst.
 Nor does the evidence establish any disruption to Respondent’s operations as a result of the
 confrontation. Although someone may have closed the door to an office in the suite used by
 physicians, there is no evidence as to why they did so. There is no other evidence establishing
 that Respondent’s business, in terms of either patient care or other functions, was disrupted by
 15 the exchange. In addition, the cases discussed by Respondent in this regard involve
 “repeated, sustained, ad hominem profanity,” as opposed to a statement that someone is
 “trouble.” *Aluminum Co. of America*, 338 NLRB 1, 3 (2002); see also *DaimlerChrysler Corp.*,
 344 NLRB at 1329-1330.

20 Because the confrontation did not take place in a patient care area, and there is no
 evidence of a negative impact on Burke’s supervisory authority or a disruption of Respondent’s
 operations, I find that the first of the *Atlantic Steel* factors, the location of the conversation,
 weighs slightly in favor of a finding that Connelly’s conduct remained protected.

25 I find that the second *Atlantic Steel* criterion – the nature of the discussion – strongly
 favors a conclusion that Connelly’s activity remained protected. The evidence establishes that
 the medication occurrence reports were a matter of ongoing concern to the entire RT
 Department, and that the RTs were upset about what they viewed as a requirement that they
 “write each other up.” The record also establishes that the RTs discussed the issue extensively
 30 amongst themselves, and that Connelly’s reading about the occurrence reports discussion in
 the minutes of the March 28 RT Department meeting immediately precipitated her confrontation
 with Burke. Indeed, in an April 2 e-mail to Hyatt, Harper states that the occurrence reporting
 issue and Connelly’s April 1 written warning “are all related,” and that the RTs were “getting
 restless” about the occurrence reports issue. Overall, because the subject matter of the
 35 conversation involved protected concerted activity, this factor strongly militates in favor of a
 finding that Connelly’s activity remained protected under the Act.

40 I find that the third of the *Atlantic Steel* factors, the nature of the outburst, also militates
 strongly in favor of protection. Even if Connelly did refer to Burke himself, as opposed to the
 occurrence reports policy, as “trouble,” that characterization would be insufficient to divest
 Connelly’s activity of the Act’s protection. In fact, it is positively genteel compared to other
 language used in the course of conduct that ultimately remained protected. See *Plaza Auto*
Center, 355 NLRB No. 85 at 2-5, *remanded in relevant part*, 664 F.3d 286 (employee’s activity
 remained protected, despite reference to owner as a “fucking motherfucker,” “fucking crook,”
 45 and “asshole,” as “a single verbal outburst of insulting profanity does not exceed the bounds of
 the Act’s protection”); *Tampa Tribune*, 351 NLRB 1324, 1324-1325 (2007), *enf denied*, 560 F.3d

50 management. *Datwyler Rubber & Plastics*, 350 NLRB at 670 (outburst took place during regular
 monthly meeting held by Respondent where employees “were free to raise workplace issues”);
Noble Metal Processing, Inc., 346 NLRB 795, 798-800 (2006) (statements made during meeting
 called by Quality Manager).

181 (4th Cir. 2009) (employee called Vice President a “stupid fucking moron”); *see also Alcoa, Inc.*, 352 NLRB 1222, 1225-1226 (2008) (employee referred to supervisor as an “egotistical fucker”); *Burle Industries*, 300 NLRB 498 (1990), *enfd*, 932 F.2d 958 (3d Cir. 1991) (employee called supervisor a “fucking asshole”). In addition, there is no evidence that Connelly’s outburst
 5 involved threats or physically intimidating conduct. *See Plaza Auto Center*, 355 NLRB No. 85 at p. 3-4, *remanded in relevant part*, 664 F.3d 286 (nature of outburst “not so opprobrious” as to deprive employee of statutory protection where no evidence of physical harm or threatening conduct); *Tampa Tribune*, 351 NLRB at 1326 (employee’s outburst remained protected where unaccompanied by physical conduct, threats, or confrontational behavior). As a result, I find
 10 that the third component of the *Atlantic Steel* analysis strongly favors a finding that Connelly’s activities remained protected.

As to the fourth component of the *Atlantic Steel* analysis, General Counsel acknowledges that Connelly’s outburst was not provoked by any unfair labor practice of
 15 Respondent. Therefore, this factor does not favor protection.

Thus, for the reasons discussed above, I find that the second and the third of the *Atlantic Steel* factors strongly support a finding that Connelly’s conduct remained protected by the Act, while the first slightly favors protection, and the fourth factor does not support such a
 20 conclusion. As a result, I find that Connelly’s activity retained the protection of the Act, and that Respondent’s April 1 written warning based upon Connelly’s confrontation with Burke was unlawful.

C. Respondent did not Violate Section 8(a)(1) of the Act by Suspending Connelly on April 5
 25 and Discharging Her on April 8

1. General Legal Principles

Under Section 8(a)(1) of the Act, an employer may not “interfere with, restrain or coerce
 30 employees in the exercise of the rights guaranteed” by Section 7. In order to determine whether an employee’s discharge violated the Act, the Board utilizes the analysis articulated in *Wright Line*, 251 NLRB 1083 (1980), *enfd*. 662 F.2d 899 (1st Cir. 1981), *cert denied*, 455 U.S. 989 (1982), approved in *NLRB v. Transportation Management Corp.*, 462 U.S. 393 (1983). To establish an unlawful discharge under *Wright Line*, the General Counsel must first prove, by a
 35 preponderance of the evidence, that the employee’s protected conduct was a motivating factor in the employer’s decision to take action against them. *Manno Electric, Inc.*, 321 NLRB 278, 280 (1996). The General Counsel makes a showing of discriminatory motivation by proving the employee’s protected activity, employer knowledge of that activity, and animus against the employee’s protected conduct. *Naomi Knitting Plant*, 328 NLRB 1279, 1281 (1999). If the
 40 General Counsel is successful, the burden of persuasion then shifts to the employer to show that it would have taken the same action even in the absence of the protected conduct. *Wright Line*, 251 at 1089; *Septix Waste, Inc.*, 346 NLRB 494, 496 (2006); *Williamette Industries*, 341 NLRB 560, 563 (2004). Once the General Counsel has met its initial burden under *Wright Line*, an employer does not satisfy its burden merely by stating a legitimate reason for the action
 45 taken, but instead must persuade by a preponderance of the credible evidence that it would have taken the same action in the absence of the protected conduct. *T&J Trucking Co.*, 316 NLRB 771 (1995); *Manno Electric, Inc.*, 321 NLRB at 280 fn. 12 (1996).

2. General Counsel Has Established a *Prima Facie* Case

50 I find that General Counsel has established a *prima facie* case that Respondent suspended and discharged Connelly in retaliation for her protected concerted activity. The

record establishes that Connelly engaged in protected concerted activity by discussing workplace issues with other RTs, including proposed staff reductions, scheduling and call-outs, seniority issues, and, after the DPH investigation, medication occurrence reporting. The record establishes that Connelly also raised these issues with management at RT Department meetings attended by Trigilia, Burke, and at times Hyatt, and with Trigilia and Burke on an individual basis. I also conclude, as discussed in Section III(B)(1), above, that Connelly was engaged in protected concerted activity during her March 31 discussion with Burke. In addition, Trigilia made repeated comments identifying Connelly as a “loudmouth” and a “troublemaker” based upon her protected concerted activity. The record therefore establishes that Respondent was aware of Connelly’s protected concerted activity at the time of her discharge.

I find that animus is established by Respondent’s having issued the April 1 written warning to Connelly for unlawful reasons, as discussed above. I also note that the record establishes animus on Trigilia’s part toward Connelly, and toward her protected concerted activities. I credit Burke’s testimony that in early 2011 Trigilia repeatedly referred to Connelly as a “loudmouth,” and a “big troublemaker...looking to cause issues in the department,” and advised Burke to “watch your back” when it came to Connelly, and “don’t trust her.” I credit as well Charland’s testimony that after he was placed on the PIP, Trigilia told her that Connelly was very vocal, and “was going to be the death of him.” These statements evince animus against Connelly and her protected concerted activity on the part of Trigilia.

General Counsel argues that the record contains evidence sufficient to generate an inference that the timing of Connelly’s discharge was suspect. Trigilia’s statements expressing hostility toward Connelly’s protected concerted activities occurred during the three months between his being placed on a PIP and Connelly’s discharge. The discharge also followed her outspoken concerns with the medication occurrence reporting policy, including the confrontation with Burke. For the reasons discussed below, however, I find that Connelly’s April 1 error in performing the ABG test was an intervening event which ultimately engendered her discharge. General Counsel argues that the evidence establishes that Respondent’s managers simultaneously discussed the April 1 written warning based upon Connelly’s March 31 confrontation with Burke and the incident which resulted in her discharge, so that, as far as Respondent was concerned, “the two events were intertwined in real time.” Although the evidence indicates that there was one meeting on April 5 regarding the written warning where Hyatt “indicated that there was a new issue that needed attention,” the testimony and documentary evidence establish that the ABG error, and the ongoing investigation, were discussed in detail in a separate meeting without Hyatt later that afternoon. In any event, the temporal proximity of the two events is insufficient to establish some sort of causal relationship, given the evidence overall to the contrary. As a result, I find that the timing of Connelly’s discharge ultimately does not support an inference that she was discharged in retaliation for her protected concerted activity.

Although I find that the timing of Connelly’s discharge does not support an inference that she was terminated for unlawful reasons, I find, on the basis of her protected activity, Respondent’s knowledge, and the evidence of animus discussed above, that General Counsel has established a *prima facie* case.

3. The Preponderance of the Credible Evidence Establishes that Respondent Would Have Discharged Connelly Absent Her Protected Concerted Activity

Respondent contends that it legitimately discharged Connelly based upon a reasonable, good faith belief that she had intentionally falsified a medical record. I find that the preponderance of the credible evidence substantiates this claim. Specifically, the evidence

establishes that Trigilia did not conduct the critical aspects of Respondent’s investigation, and was not ultimately responsible for the decision to discharge Connelly. As a result, Respondent’s investigation and decision-making process was not “tainted” by Trigilia’s animus. The preponderance of the credible evidence also establishes that Burke did not inform Trigilia, Hyatt, or any of Respondent’s other managers, that he interpreted Gerstenhaber’s statement, “I’ll cover for you this time, but don’t let it happen again,” as an acknowledgement that Gerstenhaber had in fact given Connelly a verbal order on April 1. In addition, the credible evidence establishes that Respondent’s conclusion that Connelly deliberately entered Abbasi’s name on the April 1 verbal order was not unreasonable. Finally, the evidence does not substantiate the indicia of pretext – a cursory investigation, shifting defenses, and disparate treatment – asserted by the General Counsel. Given these conclusions, and based upon the evidence overall, I find that Respondent would have discharged Connelly based upon its reasonable, good faith belief that she had intentionally falsified a medical record, regardless of her protected concerted activity.

a. Trigilia’s Involvement in Respondent’s Investigation

Although I have found that Trigilia exhibited animus toward Connelly regarding her protected concerted activity, the evidence overall establishes that Hyatt, as opposed to Trigilia, made the ultimate decision to discharge her. The evidence establishes that Hyatt was the manager with the highest level of authority involved in the decision-making process. In addition, the evidence establishes that Hyatt had in the past overruled Trigilia with respect to the discharge of RT Department employees, specifically when she discharged RT Department Supervisor Donna Ward over his objection.³¹ I therefore credit Hyatt’s testimony that she was ultimately responsible for making the decision as to what level of discipline would be appropriate. The evidence establishes no animus on the part of Hyatt toward the RT staff or their protected concerted activities. On the contrary, Hutson testified that Hyatt was receptive to the concerns of the RT staff, and after the DPH report Hyatt attended RT Department meetings more regularly and made a specific effort to ensure that RT staff concerns were communicated to management.

In addition, the evidence establishes that Trigilia did not conduct the investigation into the unsigned verbal order attributed to Abbasi, but directed Burke to do so, even though Connelly was identified as the staff member who entered the verbal order in the initial e-mail Trigilia received from Fanning.³² It was then Burke, not Trigilia, who reviewed the blood gas laboratory’s records and ran the order trail, and who (at Trigilia’s direction) initially spoke to Connelly to request an explanation. More importantly, it was Burke, and not Trigilia, who spoke to Gerstenhaber, and thereby obtained a critical piece of information which Hyatt ultimately considered in making the decision to discharge Connelly. Indeed, at Connelly’s request Burke allowed her to accompany him when he spoke to Gerstenhaber, and allowed her to question Gerstenhaber first about whether he remembered giving her the verbal order for the April 1 ABG

³¹ It is worth noting in this respect that part of the reason that Trigilia opposed Ward’s discharge was that, like Connelly, she had no history of previous discipline. Hyatt nevertheless determined that discharge was appropriate, and Ward was terminated.

³² Indeed, if Trigilia were intent on seeing Connelly discharged it would have been simple enough for him to pursue that end by investigating the April 1 ABG test himself. His foregoing that role tends to show that he was not in fact interested in acting on his animus. In fact, Burke testified that despite his previous comments regarding Connelly, Trigilia was not excited to learn that he had been asked to investigate a verbal order entered by Connelly which had apparently not been authorized by a physician.

test.³³ The interpretation of Gerstenhaber’s response – which formed a substantial basis for Respondent’s ultimate understanding that Connelly intentionally falsified the medical record by entering a verbal order without a physician’s authorization –originated with Burke, and not Trigilia. This critical component of Respondent’s investigation was therefore not tainted by any animus harbored by Trigilia, and there is no dispute that Burke had no animus toward Connelly or her protected concerted activities.

For the foregoing reasons, I find that Trigilia did not play a role in the most significant aspects of Respondent’s investigation and decision-making process. As a result, the most important elements of its process were not tainted by his animus.

b. Burke’s Characterization of Gerstenhaber’s Statement

Furthermore, I find that the credible evidence does not establish that Burke informed Trigilia, Hyatt, or any other member of Respondent’s management that, in his opinion, Gerstenhaber indicated that he had in fact given Connelly a verbal order on April 1 for the ABG test she performed on that date. Burke modified his account regarding this critical issue in so many respects over the course of his affidavits and testimony that it was ultimately unreliable. In Burke’s affidavit dated June 20, when he was still employed by Respondent, he stated that he reported, to Trigilia only, Gerstenhaber’s response, “I’ll cover for you this time, but don’t let it happen again,” without any interpretive commentary (R.S. Ex. 3, p. 3). However, in his December 14 affidavit, Burke states that he informed Trigilia and Hyatt, together, that “Gerstenhaber had said that he gave the order” (G.C. Ex. 31, p. 7). During his testimony at the hearing, Burke echoed the statements contained in his December 14, affidavit. However, he also asserted for the first time that he told Respondent’s managers that Gerstenhaber specifically said, “Yes, I remember,” giving Connelly a verbal order on April 1 (Tr. 1220-1221). In addition, he claimed for the first time that he also conveyed this information to Trigilia while on the way to Hyatt’s office, prior to their meeting (Tr. 1172-1173). Later in his testimony, Burke contradicted these contentions, stating that he did not in fact communicate this interpretation of Gerstenhaber’s remarks to anyone in Respondent’s management prior to his discharge (Tr. 1297-1298).

Burke altered his testimony regarding his actual discussion with Connelly and Gerstenhaber in a similar manner. In his June 20, affidavit, Burke stated that when Connelly asked Gerstenhaber whether he remembered giving the verbal order on April 1, Gerstenhaber responded by saying only, “I’ll cover for you this time, but don’t let it happen again” (R.S. Ex. 3, p. 3). However, in his December 14 affidavit, Burke also stated that he concluded from this remark that, “Gerstenhaber confirmed that he had given Connelly a verbal order for the ABG performed on April 1, 2011” (G.C. Ex. 31, p. 7). Then, during his direct testimony, Burke claimed for the first time that Gerstenhaber responded, “Yes, I do remember,” when Connelly asked whether he remembered giving her the verbal order on April 1 (Tr. 1167). However, when questioned by me, Burke testified consistently with his June 20 affidavit, asserting that Gerstenhaber indicated that he would “cover” for Connelly by “saying” that he had given the verbal order, as opposed to having actually given the verbal order on April 1 (Tr. 1219-1220).³⁴

³³ Based upon Connelly’s spontaneity when testifying at the hearing, it is entirely plausible to me that she began the conversation with Gerstenhaber and immediately asked him whether he remembered giving her the verbal order.

³⁴ Gerstenhaber testified that to the extent that he recalled being asked whether he remembered something during the conversation, Burke asked him whether he had a recollection of the ABG test itself, and not providing a verbal order to cover it (Tr. 2094-2095).

By contrast, Hyatt’s testimony on the issue was consistent and plausible. Hyatt testified that prior to Connelly’s discharge, Burke and Trigilia informed her only that Gerstenhaber had offered to “cover” for Connelly, and not acknowledged that he had actually given Connelly a verbal order. Hyatt further testified that after Connelly filed the first charge in the instant case alleging that she was discharged in retaliation for her protected concerted activity, she met with Burke, who at that time was still employed by the hospital, and asked him to review the investigation with her. Hyatt asked Burke what, in his opinion, Gerstenhaber meant when he said, “I’ll cover for you this time, but don’t let it happen again.” Burke responded that he believed Gerstenhaber meant that he had not given Connelly a verbal order on April 1. Hyatt testified that Burke responded in the same manner to questions posed by Respondent’s attorney Brian Clemow during a meeting in connection with the investigation of the charge. I credit Hyatt’s testimony in this regard, and find that prior to leaving his employment with the hospital, Burke never informed any of Respondent’s managers that he actually interpreted Gerstenhaber’s statement as an admission that he had in fact given Connelly a verbal order on April 1.

It must also be noted that the circumstances in which Burke provided his second affidavit raise at least the possibility of biased testimony. The evidence establishes that on December 9, Burke resigned his position in lieu of termination, after an RT complained that Burke directed her to report that a particular medication had not been administered because the “patient refused,” when the RT actually had not had time to administer all of the medications as ordered during her shift. Hyatt concluded after interviewing the RT, other RT witnesses to the conversation, and Burke himself that Burke had placed the RT involved in a position where she was effectively forced to falsify the medical record. Hyatt therefore terminated Burke, but provided him with the opportunity to resign, which he did. Five days later, Burke provided his second affidavit, contending for the first time that Gerstenhaber had actually admitted giving Connelly a verbal order on April 1 for the ABG test, and that he had communicated as much to Trigilia and Hyatt. This sequence of events raises the possibility that his change in position regarding the critical issues involved in the investigation preceding Connelly’s discharge is attributable to bias.

For all of the foregoing reasons, I decline to credit Burke’s testimony that he informed Trigilia, Hyatt, Harper, or any other manager that Gerstenhaber had in fact acknowledged giving Connelly a verbal order on April 1 for the ABG test, at any time prior to Burke’s discharge on December 9. Instead, I find that Hyatt was presented with Gerstenhaber’s statement, “I’ll cover for you this time, but don’t let it happen again,” and reasonably interpreted that remark to mean that Gerstenhaber had not given Connelly a verbal order on April 1.³⁵

c. Connelly’s Entry of the April 1 Verbal Order Under Abbasi’s Name

Furthermore, I find that Respondent’s conclusion that entering Abbasi’s name was deliberate, as opposed to a “clerical data entry error,” on Connelly’s part was not unreasonable. In fact, the evidence adduced at the hearing overwhelmingly supports the conclusion that

³⁵ The conclusion that Gerstenhaber had not in fact given Connelly a verbal order is consistent with Respondent’s policy strongly discouraging verbal orders in non-emergent situations as articulated by Teba, and actual practice among the RTs, as discussed by Hutson and Slowenski in their testimony. See Section III(A), above. It is also consistent with Gerstenhaber’s testimony that he did not give permission for verbal orders in non-emergent situations.

Connelly intentionally selected Abbasi’s name, and entered Abbasi into the Meditech system as the physician which had ordered the ABG mistakenly performed on April 1, and the physician to whom Connelly reported the results. Connelly provided several explanations for the appearance of Abbasi’s name in the Meditech system. In her affidavit, she stated that because she failed to hit “F9,” the Meditech system defaulted to the name of the attending physician for the building and floor, which was Abbasi.³⁶ She stated that this explanation was based on what she was told, perhaps by Donna Ward. At the hearing, she testified that she did in fact hit the “F9” button, but insisted that she did not type in Abbasi’s name or choose it from a menu of names. Then she appeared to contend that the “F9” button did require the selection of names from a menu, but that sometimes a particular name “magically appears.” Finally, Connelly testified that she did not know how Abbasi’s name ended up on the verbal order she entered, or how the “F9” aspect of the Meditech system works.

Information Services Supervisor Rena Susca explained the “F9” function and the entry of physician names through the order entry module in the Meditech system. After an RT signs onto the computer and onto the Meditech system, they select the order entry module and choose the “enter orders” routine. The first prompt which appears is for the ordering physician, a mandatory field which cannot be bypassed. There is no default physician which appears in the order entry module. Instead, the RT chooses a physician by typing in the physician’s full name or a mnemonic for each physician’s name. In addition, the RT can choose a physician by hitting the “F9” key, which will bring up an entire dictionary of medical providers. The RT can scroll down the list of physicians, which is organized alphabetically by mnemonic, with the mouse or arrows, and choose the specific physician’s name. They can also hit the first letter of the physician’s last name, which will take them to the first of the physicians on the list whose last name begins with that letter. Hitting the “F9” key repeatedly results only in beeping. Susca prepared “screenshots” of the provider lists which would be generated by hitting the “F9” key using the current (5.6) version of Meditech, and when the previous version (5.5) of Meditech was in use, prior to June 2011. Abbasi’s name was not the first provider name on the list for either version, indicating that it would have to be specifically selected from the list of providers.

It should also be noted that Connelly was aware that Abbasi’s name had been entered into the system in connection with the verbal order April 1 ABG test, regardless of the technological specifics which brought this result about. When Burke initially discussed the unsigned verbal order with her, she was fully aware that she had entered it into the Meditech system under Abbasi’s name. As noted by Burke during his investigation, she did not make efforts to correct the medical record, or bring the error to someone’s attention.

In light of Connelly’s inability to recall the events which resulted in Abbasi’s name being placed on the order for the April 1 ABG, her repeated conjecture about how this occurred, and Susca’s apparent expertise, I find that the preponderance of the evidence establishes that Connelly chose Abbasi’s name from the drop down menu which is produced by hitting the F9 key. This was the manner in which Trigilia described the operation of the Meditech system to Hyatt when they met to discuss the verbal order for the April 1 ABG test attributed to Abbasi. As a result, Respondent’s conclusion that Connelly’s error was not an inadvertent mistake was not unreasonable.

d. General Counsel’s Contentions Regarding Pretext

General Counsel initially contends, in arguing that Respondent’s asserted reason for

³⁶ In fact, Abbasi was not the attending on Milne 2 on April 1.

Connelly's discharge was pretextual, that Respondent conducted a cursory investigation prior to discharging Connelly. The Board has held that the failure to conduct an adequate investigation, and to give the accused employee an opportunity to explain allegations of misconduct, demonstrate pretext. *Manorcare Health Services – Easton*, 356 NLRB No. 39, at p. 3, 26
 5 (2010), *enf'd*, 661 F.3d 1139 (D.C. Cir. 2001); *North Hills Office Services*, 344 NLRB 1083, 1097 (2005); *New Orleans Cold Storage Co.*, 326 NLRB 1471, 1477 (1998), *enf'd*, 201 F.3d 592 (5th Cir. 2000).

The evidence here establishes that Respondent conducted an adequate investigation.
 10 The unsigned April 1 verbal order came to Trigilia's attention as the result of a routine hospital record-keeping procedure, and was not specifically discovered or sought out by him. After being directed by Trigilia to conduct the investigation, Burke reviewed the laboratory's records and the audit trail for the unsigned verbal order. He spoke to Connelly to determine how
 15 Abbasi's name was incorrectly entered into the Meditech system on the verbal order, and why she did not request assistance. Hyatt directed Trigilia and Burke to conduct additional investigation, and to speak with Gerstenhaber after Connelly identified him as the source of the verbal order. Burke spoke to Connelly again, and then spoke to Gerstenhaber regarding whether he had given the verbal order on April 1. Burke allowed Connelly to participate in his
 20 conversation with Gerstenhaber, and even permitted her to begin the discussion by asking Gerstenhaber whether he remembered giving her the verbal order on April 1 for the ABG test.³⁷ Burke then reported Gerstenhaber's response that he would cover for Connelly to Trigilia and Hyatt, and only at that point was Connelly suspended pending further investigation. Trigilia again reviewed the audit trail, and the matter was discussed between Burke, Trigilia, Hyatt, and Harper. In addition, Trigilia spoke with Abbasi, who confirmed that she had not ordered the test
 25 and had not received the results, and refused as a result to sign the verbal order.³⁸

The evidence therefore establishes that Respondent in the course of its investigation spoke with Connelly twice, reviewed the relevant documents at least twice, and spoke with both
 30 physicians (Abbasi and Gerstenhaber) regarding the unsigned April 1 verbal order before concluding that discharge was appropriate. This is a clearly distinct from investigations which the Board has found so inadequate that they evince employer pretext. See, e.g., *Manorcare Health Services – Easton*, 356 NLRB No. 39 at 3, 26 (discipline pretextual where employer's "frenzy of activity involved zero investigation or interest in the underlying events" of employee's alleged misconduct); *North Hills Office Services*, 344 NLRB at 1097-1098 (manager only
 35 investigated and determined that employee's alleged misconduct had been explicitly approved by supervisor after employee's discharge); *New Orleans Cold Storage Co.*, 326 NLRB at 1477 (manager issued warnings without investigating, and responded to employee's explanations by apologizing but refusing to rescind them).

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³⁷ General Counsel emphasizes Trigilia's confusion during the hearing about the importance of consulting with Gerstenhaber, arguing that this tends to establish that Respondent's investigation was cursory. I find Trigilia's testimony in this regard less significant in light of the
 45 evidence that Burke actually did speak to Gerstenhaber regarding the April 1 ABG test as part of the investigation, and that his conversation with Gerstenhaber was reported to Hyatt.

³⁸ General Counsel makes much of Trigilia's alleged refusal to call Connelly after her suspension and discuss the issues with her further. General Counsel argues that documentary evidence undermines Trigilia's contention that he attempted to reach Connelly but was unable to do so. I find that the evidence discussed above establishes that Respondent conducted an
 50 adequate investigation regardless of any attempt of Trigilia's to reach Connelly by phone after her suspension.

General Counsel also contends that Respondent offered shifting defenses in articulating its reasons for discharging Connelly. It is well-settled that the assertion of shifting defenses for an adverse employment action constitutes evidence of pretext. *See, e.g., Airport 2000 Concessions*, 346 NLRB 958, 978 (2006). However, the evidence does not establish that Respondent asserted differing or contradictory reasons for Connelly’s suspension and discharge. General Counsel bases its argument in this regard on a purported conflict between the reasons for Connelly’s discharge asserted in Respondent’s position statement and during the testimony of Trigilia, whom General Counsel describes as “the decision maker,” and “Respondent’s primary witness.” As discussed in further detail above, Trigilia was neither Hyatt’s description during her testimony of the reason for Connelly’s discharge – that Respondent believed that Connelly performed the ABG test on April 1 without any physician’s order, and falsified a medical record by actually entering a physician’s name into the Meditech system as having issued the order and received the results – is consistent with the reasons articulated by Respondent in its position statement. That Trigilia had other, additional concerns with the April 1 ABG test, such as the invasiveness of the procedure or the fact that it had been performed on the wrong date, does not constitute a shifting defense.³⁹

Finally, General Counsel argues that the evidence establishes disparate treatment, long-considered to be indicative of pretext, which demonstrates that Respondent did not in fact consider Connelly’s conduct a serious offense warranting discharge. I find that the record supports Respondent’s case in this regard. In particular, I find that Respondent had previously discharged an RT for falsifying the medical record, and indicated that it considered this conduct an offense for which immediate discharge was appropriate. The evidence establishes that RT Lulu Irabor was discharged in 2008 for indicating in the medical record that she had reported the results of an ABG test to the physician when in fact she had not. Irabor was discharged within three days after incorrectly entering that the results had been reported. Notes indicate that in making the decision Hyatt “concurred that there is zero tolerance for falsifying medical documentation and [it] is cause for immediate dismissal.”⁴⁰ There was no evidence contradicting Irabor’s assertion that she simply forgot to report the results of the ABG test to the physician, and no suggestion that she entered the name of an entirely different physician into the medical record. Regardless of these potentially mitigating factors, Respondent discharged her immediately. This is significant evidence that in discharging Connelly Respondent acted in accordance with its previous practice when confronted with this type of offense. It should also be noted that Hyatt immediately discharged Burke for placing an RT in a position where they would be forced in practical terms to falsify a medical record. While Burke was a Supervisor and not an RT, I consider this evidence relevant in that it bears directly on Respondent’s

³⁹ General Counsel contends that Respondent “falsely claimed” in its position statement that it “increased the severity of its disciplinary policy” after the DPH investigation, and decided to discharge Connelly as a result. What the position statement actually says is that Hyatt and Harper’s conclusion that discharge was appropriate was, among other considerations, “influenced” by the DPH citation and “the recent emphasis on the importance of accurate documentation in meeting[s] of the Respiratory Therapy Department” (G.C. Ex. 49). Respondent does not claim that it “increased the severity of its disciplinary policy.”

⁴⁰ The documents pertaining to Irabor do not indicate that she “had a repeated practice of entering false information into the record, raising actual harm to patients as a result,” as General Counsel contends. Instead, the documents state that the physician involved “recalls this not being the first time this has happened,” and make no mention of an adverse outcome to any patient. Because Irabor was discharged in June 2008, she was not included on the list of disciplined employees during the period August 1, 2008 through June 3, 2011; this omission is not mendacious in nature.

conception of the gravity of the particular offense which it believed Connelly committed, and occurred in the RT Department. Overall it tends to show that, with respect to the RT Department, Respondent considered falsification of a medical record to be an offense warranting immediate discharge.

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General Counsel also argues that disparate treatment is established by evidence that in November RT Anne Marie Iosa was disciplined, but not discharged, for falsification of a medical record, despite her previous disciplinary history. On November 11, Iosa was issued a final written warning after she entered into a patient's medical record that a treatment was not given because the necessary medication was not available. I credit Hyatt's testimony that Iosa was given a final written warning, as opposed to discharged, because prior to September RTs had been permitted to chart that a medication was not available, and did so as a common practice. Hyatt explained that the entire RT staff was given in-service training, and a revised policy regarding charting on missed medications, pursuant to a management decision to approach the problem of missed medication charting through policy and education, as opposed to individual disciplinary action. Furthermore, Iosa's "falsification" differs from Connelly's in that Iosa correctly indicated in the medical record that the medication was missed, but used a reason which was no longer considered appropriate pursuant to Respondent's policies. Ironically, Iosa was identified by Hyatt and currently employed RTs as one of the most vocal RTs in the department, and at least one of the currently employed RTs thought her a likely target for retaliatory discipline. As a result, I do not find that Iosa's discipline tends to establish that Respondent's discharge of Connelly was disproportionate to its treatment of other employees who had committed similar misconduct.⁴¹

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The other incidents which General Counsel contends establish disparate treatment are simply not relevant. General Counsel claims that Girman was only issued a written warning, four months after Connelly's discharge, although he had "verbally and physically assaulted a patient." In fact, the evidence establishes that Respondent had concluded based upon its investigation that Girman was only inappropriately loud in the patient's presence. The employee that General Counsel claims was only warned for administering medication to a patient without a doctor's order was in fact a former patient of Respondent's who had been treated for a traumatic brain injury, and worked for 20 years at a residential rehabilitation facility not encompassed by Respondent's license. Contrary to General Counsel's contention, there is no evidence that Respondent "ignored" a patient advocate line complaint regarding the RT care being provided to the patient; there is no evidence to establish what happened after the complaint was filed. Finally, General Counsel argues that Respondent's failure to discipline a physician who inadvertently prescribed an incorrect dosage of insulin evinces disparate treatment of Connelly. I decline to make such a finding, as there is no evidence that the physician in question was even Respondent's employee, as opposed to an independent contractor, and no evidence to establish that Respondent's disciplinary policies for physicians are identical to those applicable to RTs.

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⁴¹ I also do not find that the final written warning issued to Nelysa Couvertier on May 16, 2010 for falsifying a medical record evinces disparate treatment of Connelly. Couvertier was a CNA, not an RT, and there is no evidence as to what specifically constituted her falsification of a medical record. Given their different duties, departments, and lines of supervision, and the discharge of Irabor discussed above, I am not prepared to conclude that the final written warning issued to Couvertier is probative evidence of disparate treatment. The other employees who received discipline for "falsification" during the period August 1, 2008 through June 3, 2011 falsified time records, with the exception of a benefits employee in the Outpatient department, whose written warning for "falsification" would not have involved a medical record.

For all of the foregoing reasons, I find that the evidence does not establish disparate treatment indicative of pretext, or demonstrating that Respondent did not consider Connelly's conduct a serious offense warranting discharge. As a result, for all of the reasons discussed above, I find that the preponderance of the credible evidence establishes that Respondent reasonably concluded that Connelly had falsified a medical record, and would have discharged her on that basis regardless of her protected concerted activity. I therefore find that Connelly's discharge did not violate Section 8(a)(1) of the Act, and recommend that this allegation be dismissed.

D. Respondent Violated Section 8(a)(1) of the Act by Prohibiting Connelly from Discussing Terms and Conditions of Employment

The evidence establishes that Respondent violated Section 8(a)(1) when Employment Administrator Bryana Minor prohibited Connelly from discussing her April 1 written warning. As discussed above, on the afternoon of Friday, April 1, Connelly met with Minor, Burke, and Trigilia, and discussed the written warning she had just received, and the occurrence reports issue. There is no real dispute that during this meeting, Minor told Connelly, Burke, and Trigilia that they should not discuss these issues with anyone else over the weekend, and resume their conversation the following week.

I find that by doing so, Minor effectively imposed a rule prohibiting Connelly from discussing her discipline and the ongoing conflict regarding occurrence reports with her co-workers. In order to determine whether such a rule is permissible, the Board considers whether the employer's asserted business justifications outweigh employees' Section 7 rights to discuss their terms and conditions of employment. *Verizon Wireless*, 349 NLRB 640, 658 (2007), citing *Caesar's Palace*, 336 NLRB 271, 272 (2001). The Board has repeatedly held that rules restricting employee discussion of discipline violate Section 8(a)(1). *Verizon Wireless*, 349 NLRB at 658-659; *SNE Enterprises*, 347 NLRB 472, 491-493 (2006), *enf'd*, 257 Fed.Appx. 642 (4th Cir. 2007); *Westside Community Mental Health Center*, 327 NLRB 661, 666 (1999). Employees have a protected interest in discussing the circumstances of discipline, so that they are aware of "the nature of discipline being imposed, how they might avoid such discipline, and matters which could be raised in their own defense." *Verizon Wireless*, 349 NLRB at 658. These considerations are particularly acute here, where the discipline involved a confrontation regarding the completion of occurrence reports, itself a controversial issue within the RT Department. In addition, because the meeting took place on a Friday afternoon, and Minor was suggesting a hiatus in any discussion until the next week, the interim period encompassed predominantly non-work time as far as Connelly was concerned.

I find in these circumstances that Respondent has not advanced a business justification sufficient to outweigh the employees' Section 7 rights. Minor testified that she intended her remark to establish a "cooling off period," to give those involved "a chance to discuss it and come to get all the facts out, and so forth." Minor's attempt to provide the individuals involved with a respite from what were clearly difficult and contentious issues and an emotionally charged situation is certainly understandable. However, the manner in which she went about doing so impermissibly restricted Connelly's Section 7 right to discuss her discipline and working conditions with co-workers. As a result, I find that Minor's statement violated Section 8(a)(1) of the Act.⁴²

⁴² I do not find, however, that Minor's remark evinces animus toward Connelly or her protected activity relevant to the *Wright Line* analysis regarding her discharge. I find that her

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E. Respondent Did Not Violate Section 8(a)(1) by Threatening Connelly with Job Loss for Engaging in Protected Concerted Activity

5 I find that the record does not establish that Respondent unlawfully threatened Connelly
with job loss in retaliation for her protected concerted activity. Connelly testified that during a
meeting with Walter Harper on April 4, Harper told her that, “he had heard about the respiratory
department and that there will be no more complaining, and that there will only be a positive
work environment here, and that complainers will have to go.” Harper denied making this
10 statement, which would tend to restrain or coerce an employee in the exercise of their Section 7
rights by raising the distinct possibility of discharge. See, e.g., *Palace Hotel and Casino*, 358
NLRB No. 77, at p. 5, 7 (2012) (supervisor’s remark that employee would be discharged if he
did not keep quiet and refrain from complaining unlawful); *Swardson Painting Co.*, 340 NLRB
179, 187 (2003) (rule stating “Any complaining or causing problems will be reason for
15 discharge” violates Section 8(a)(1)).

Here, I credit Harper’s testimony over Connelly’s, as it is more consistent with the weight
of the evidence overall. The evidence establishes that, as he testified, Harper was one of the
Human Resources officials tasked with making themselves available to the RTs to address
20 workplace issues in the wake of the DPH investigation. For example, Hyatt’s
Recommendations following the DPH investigation state that Harper was “to meet with the RT
staff” without its Supervisor or Director, to “assess the environment,” and “get a closer handle on
the issues.” The problems Hyatt was particularly concerned with were the RT staff’s “lack of
trust/fear of retaliation,” and getting “to the root of issues in the department.” As a result, Hyatt’s
25 Recommendations specify that Harper was to encourage the RT staff to raise issues directly
with him. The evidence indicates that they did so, illustrated by, for example, Harper’s March 31
e-mail to Hyatt describing a “considerable stir” regarding the occurrence reports, which Harper
characterized as “the new RT requirement that staff report staff,” clearly the perspective of the
RTs themselves. On April 2, again discussing the occurrence reports, Harper e-mailed Hyatt, “I
30 could tell from the reaction by some that this appeared to be new and [they] had questions
about it and concerns,” and stated that the RTs were “getting restless.” As a result, the
documentary evidence from the period immediately preceding Harper’s April 4 meeting with
Connelly establishes, consonant with Harper’s testimony, that he was directly interacting with
the RTs and communicating their perspective to Hyatt.

35 Given this context, I find Harper’s testimony and his notes of the April 4 meeting more
probative than Connelly’s assertion that Harper told her that “complainers will have to go.” The
evidence does establish that Harper and Connelly discussed the April 1 written warning, and
Connelly’s conduct, at the April 4 meeting. I credit Harper’s testimony that Connelly contended
40 that if she had received a written warning, Burke should have as well, an argument she also
made to Minor. Harper’s notes and testimony indicate that they discussed the turmoil in the RT
Department, and that Connelly said that there was still significant disquiet among the RTs.
Harper then asked whether Connelly was involved with that, and whether she believed that
complaining to the other RTs regarding her warning was improving or exacerbating the
45 situation. I therefore find it plausible that Harper and Connelly discussed her warning and the
fact that she had complained about it with the other RTs. However, in the overall context
described above, a statement on Harper’s part that “complainers will have to go” is not
probable.

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statement constituted more of a technical violation ancillary to her attempt to impose a hiatus in
the conflict between Connelly and Burke and Trigilia, and not an expression of animus.

Therefore, I find that, although Harper and Connelly discussed her own conduct, the evidence overall does not establish that the specific statement Connelly attributes to him, “complainers will have to go,” was in fact made. As a result, I find that Respondent did not violate Section 8(a)(1) by threatening employees with the loss of their jobs in retaliation for their protected concerted activity, and recommend that this allegation be dismissed.

Conclusions of Law

1. At all material times, the Respondent, Gaylord Hospital, has been an employer engaged in commerce within the meaning of Section 2(6) and (7) of the Act.

2. Respondent violated Section 8(a)(1) of the Act by issuing a written warning to Jeanine Connelly on April 1, 2011 in retaliation for her protected concerted activities.

3. Respondent violated Section 8(a)(1) of the Act by prohibiting employees from discussing terms and conditions of employment on April 1, 2011.

4. Respondent has not violated the Act in any other manner.

5. The above-described unfair labor practices affect commerce within the meaning of Section 2(2), (6), and (7) of the Act.

The Remedy

Having found that Respondent has violated the Act, I shall recommend that it cease and desist therefrom and take certain affirmative action necessary to effectuate the Act’s purposes.

Having discriminatorily disciplined Jeanine Connelly in retaliation for her protected concerted activities, Respondent shall be required to remove from its files all references to the unlawful written warning dated April 1, 2011, and to notify Connelly in writing that this has been done and that the discipline shall not be used against her.

On these findings of fact and conclusions of law and on the entire record, I issue the following recommended⁴³

ORDER

Respondent Gaylord Hospital, Wallingford, Connecticut, its officers, agents, successors, and assigns, shall

1. Cease and desist from

(a) Disciplining or otherwise discriminating against employees in retaliation for their protected concerted activities.

⁴³ If no exceptions are filed as provided by Section 102.46 of the Board’s Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Section 102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.

(b) Prohibiting employees from discussing their terms and conditions of employment.

(c) In any like or related manner interfering with, restraining or coercing employees in the exercise of the rights guaranteed them by Section 7 of the Act.

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2. Take the following affirmative action necessary to effectuate the policies of the Act

(a) Within 14 days of the date of this Order, remove from all files any reference to the unlawful April 1, 2011 written warning, and within 3 days thereafter, notify Jeanine Connelly in writing that this has been done and that the written warning will not be used against her in any way.

(b) Within 14 days after service by the Region, post at its facility in Wallingford, Connecticut, copies of the attached notice marked "Appendix."⁴⁴ Copies of the notice, on forms provided by the Regional Director for Region 34, after being signed by Respondent's authorized representative, shall be posted by the Respondent and maintained for 60 consecutive days in conspicuous places including all places where notices to employees are customarily posted. In addition to physical posting of paper notices, notices shall be distributed electronically, such as by e-mail, posting on an intranet or an internet site and/or other electronic means if Respondent customarily communicates with its employees by such means. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. In the event that, during the pendency of these proceedings, the Respondent has gone out of business or closed the facility involved in these proceedings, the Respondent shall duplicate and mail, at its own expense, a copy of the notice to all current employees and former employees employed by the Respondent at any time since April 1, 2011.

(c) Within 21 days after service by the Region, file with the Regional Director a sworn certification of a responsible official on a form provided by the Region attesting to the steps that Respondent has taken to comply.

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Dated: Washington, DC September 6, 2012

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Lauren Esposito
Administrative Law Judge

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⁴⁴ If this Order is enforced by a judgment of a United States court of appeals, the words in the notice reading "Posted by Order of the National Labor Relations board" shall read "Posted Pursuant to a Judgment of the United States Court of Appeals Enforcing an Order of the National Labor Relations Board."

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APPENDIX

NOTICE TO EMPLOYEES

Posted by Order of the
National Labor Relations Board
An Agency of the United States Government

The National Labor Relations Board has found that we violated Federal labor law and has ordered us to post and obey this Notice.

FEDERAL LAW GIVES YOU THE RIGHT TO

- Form, join or assist a union
- Choose representatives to bargain with us on your behalf
- Act together with other employees for your benefit and protection
- Choose not to engage in any of these protected activities

WE WILL NOT discipline or otherwise discriminate against you in retaliation for your protected concerted activities.

WE WILL NOT prohibit you from discussing your terms and conditions of employment.

WE WILL within 14 days of the date of the Board's Order, remove from all files any reference to the unlawful April 1, 2011 written warning issued to Jeanine Connelly, and, within three days thereafter, notify Connelly in writing that this has been done and that the written warning will not be used against her in any way.

GAYLORD HOSPITAL

(Employer)

Dated _____ By _____
(Representative) (Title)

The National Labor Relations Board is an independent Federal agency created in 1935 to enforce the National Labor Relations Act. It conducts secret-ballot elections to determine whether employees want union representation and it investigates and remedies unfair labor practices by employers and unions. To find out more about your rights under the Act and how to file a charge or election petition, you may speak confidentially to any agent with the Board's Regional Office set forth below. You may also obtain information from the Board's website: www.nlr.gov.

A.A. Ribicoff Federal Building and Courthouse, 450 Main Street, Suite 410
Hartford, Connecticut 06103-3022
Hours: 8:30 a.m. to 5 p.m.
860-240-3522.

THIS IS AN OFFICIAL NOTICE AND MUST NOT BE DEFACED BY ANYONE

THIS NOTICE MUST REMAIN POSTED FOR 60 CONSECUTIVE DAYS FROM THE DATE OF POSTING AND MUST NOT BE ALTERED, DEFACED, OR COVERED BY ANY OTHER MATERIAL. ANY QUESTIONS CONCERNING THIS NOTICE OR COMPLIANCE WITH ITS PROVISIONS MAY BE DIRECTED TO THE ABOVE REGIONAL OFFICE'S COMPLIANCE OFFICER, 860-240-3006.