

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

ST. FRANCIS HOSPITAL & HEALTH CENTER

Employer

and

Case 03-RC-107520

**1199 SEIU, UNITED HEALTHCARE WORKERS
EAST**

Petitioner

DECISION AND DIRECTION OF ELECTION

St. Francis Hospital and Health Center (“the Hospital”) operates an acute-care hospital in Poughkeepsie, New York. The Petitioner seeks to represent a unit of all full-time, part-time, and per-diem service and maintenance workers at the Hospital.

The parties disagree over the scope of the unit. The Hospital contends that the unit must also include the following two groups of employees: (1) home-health aides, home-health aides II (LHC),¹ licensed homemakers, licensed live-ins, patient-care scheduler (LHC), personal care aides, personal care aides (LHC), sitters, sitter/homemakers, office specialists, administrative assistant, and community liaison; and (2) teaching assistants, clinical education aides, and office specialists. The first group of employees is referred to herein as “home-health aides” and the second group of employees is referred to as “teaching assistants.”

¹ “LHC” refers to licensed home care.

It is uncontested that the acute-care hospital itself is a single facility. Most of the home-health aides work for St. Francis Home Care Services, Inc. ("HCS"), a separate corporate entity from the Hospital, which is located in a facility seven miles from the Hospital. A small number of home health aides work for St. Francis Hospital Certified Home Health Services ("CHHS"), a department of the Hospital, which has its own office in the same remote facility as HCS. The teaching assistants work in the Hospital's preschool and daycare programs. The preschool program is run by St. Francis Preschool, Inc., a separate corporation from the Hospital. The preschool program has three locations, ranging from 3 to 13 miles from the Hospital. The daycare program has two sites, one located on the Hospital campus, and the other four miles away.²

For the reasons discussed below, based on the record and relevant Board law, I find that the petitioned-for unit is appropriate and need not include the home-health aides or the teaching assistants.

Board Law

The Board has issued regulations enumerating the appropriate units in an acute-care hospital. 29 C.F.R. § 103.30(a). Absent extraordinary circumstances, only the following units are appropriate under the Board's health-care rule:

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards.

² The record is unclear whether the daycare program is run by St. Francis Preschool, Inc. or the Hospital.

Id.

The Board has consistently held that a single-facility unit is presumptively appropriate, unless the unit has been so effectively merged or is so functionally integrated with another facility that it has lost its separate identity. *New Britain Transp. Co.*, 330 NLRB 397, 397 (1999). The single-facility presumption applies to the healthcare industry, in both the acute-care and non-acute-care contexts. See, e.g., *Mercy Med. Ctr. San Juan*, 344 NLRB 790, 790 (2005); *Manor Healthcare Corp.*, 285 NLRB 224 (1987). To determine whether the party opposing a single-facility unit has rebutted the presumption of appropriateness, the Board considers “(1) central control over daily operations and labor relations, including extent of local autonomy; (2) similarity of employee skills, functions, and working conditions; (3) degree of employee interchange; (4) distance between locations; and (5) bargaining history, if any.” *Hilander Foods*, 348 NLRB 1200, 1200 (2003). Separate supervision and degree of interchange are the most important factors, *Heritage Park Health Care Ctr.*, 324 NLRB 447, 452 (1997), *enforced mem.* 159 F.3d 1346 (2d Cir. 1998) (Table), though no one factor is determinative, *St. Luke’s Health Sys.*, 340 NLRB 1171, 1173 (2003). Whether the single-facility presumption has been rebutted requires a case-by-case, fact-intensive analysis. See *Dattco, Inc.*, 338 NLRB 48, 50 (2002).

There are few cases involving the application of the Board’s health-care rule to a multi-facility healthcare system that includes an acute-care hospital, as well as non-acute facilities. Nonetheless, precedent suggests that the health-care rule does not automatically mandate the inclusion in the same unit all employees in such a system who fall within one of the rule’s categories (e.g., all registered nurses) if they work at

separate facilities. Employees at a non-acute-care facility within such a system need not be in the same unit as employees at an acute-care facility. See *St. Luke's Health Sys.*, 340 NLRB at 1171 (holding that the petitioned-for unit must include professional employees at all of the healthcare system's multiple non-acute-care clinics, but noting that employees at the system's acute-care hospital could be excluded); *Visiting Nurses Ass'n of Central Ill.*, 324 NLRB 55, 55-56, 58-59 (1997) (finding appropriate a unit of registered nurses at a non-acute-care home-health service provider that excluded nurses at an affiliated acute-care hospital); cf. *Stormont-Vail Healthcare, Inc.*, 340 NLRB 1205, 1205-07 (2003) (finding that the petitioned-for unit must include all registered nurses in a regional healthcare system that contained both acute-care and non-acute-care facilities, but doing so under the standard for a multi-facility unit rather than the health-care rule). Indeed, the Board has described the health-care rule as "a rule that is designed to cover the more typical free-standing acute care hospital." *Child's Hosp.*, 307 NLRB 90, 92 (1992). Because the single-facility presumption applies in the acute-care context, the Board will decide whether a unit is appropriate in such circumstances based on whether the presumption has been rebutted. In *Visiting Nurses Association*, supra, for example, the Board held that the unit of nurses at a non-acute-care facility was appropriate because the single-facility presumption had not been rebutted. 324 NLRB at 55-56.

Application of Board Law To This Case

Under the Board's health-care rule, a unit of non-professional employees at an acute-care hospital must include all non-professional employees. See 29 C.F.R. §

103.30(a)(8). The parties have stipulated that the Hospital is an acute-care hospital.³ However, the Board's health-care rule does not automatically mandate the inclusion of the home-health aides and the teaching assistants in the petitioned-for unit, because it is uncontested that they work at separate facilities from the acute-care hospital. See *Visiting Nurses Ass'n*, 324 NLRB at 55-56. Instead, the question of whether the home-health aides and the teaching assistants should be included in the unit depends upon whether the single-facility presumption has been rebutted.

Because both the home-health aides and the teaching assistants work at non-acute-care facilities, their exclusion from the petitioned-for unit would not render them a residual, non-conforming unit in violation of the Board's health-care rule. Nor would that rule prevent the formation of a separate unit of either group of employees, provided that such a unit was otherwise appropriate.

I. Home-Health Aides

There are approximately 130 home-health aides employed by HCS, a separate corporation from the Hospital that maintains its own payroll and is independently licensed. As noted above, HCS is located in a facility seven miles from the Hospital. There are approximately six home-health aides employed by CHHS, a department of the Hospital. CHHS has its own office, located in the same facility as HCS.

HCS and CHHS home-health aides assist and care for patients in their homes or in institutions such as nursing homes. The various classifications within this category differ in the services that they provide and the duration of their stay. A home-health

³ Hasting Health Systems, Inc. is the parent company of the Hospital and other related entities, including St. Francis Home Care Services, Inc. and St. Francis Preschool, Inc. As noted above, St. Francis Hospital Certified Home Health Services is a department of the Hospital.

aide assists patients with tasks such as bathing, eating, and exercising, checks vital signs, changes non-sterile dressing, and performs some housekeeping. Their shifts can vary in frequency and duration. A licensed live-in performs all of the same tasks as a home-health aide and also lives full-time in the patient's home. A personal care aide has less training and does not check vital signs, change dressings, or assist with a patient's exercise plan. A sitter/homemaker provides non-medical services such as meal preparation, housekeeping, and companionship; they can help the patient with certain activities, but only with the assistance of another aide. A sitter performs these same tasks, but typically in an institutional setting such as a nursing home. A scheduler, office specialists, and a community liaison work in the HCS office. An administrative assistant and office specialists work in the CHHS office.⁴

In reaching the conclusion that a single-facility unit is appropriate, I rely on the following analysis and record evidence, as well as the case law referenced above.

A. Central Control of Daily Operations and Labor Relations

In determining whether the single-facility presumption has been rebutted, the key consideration for this factor is whether meaningful local autonomy exists over day-to-day matters regarding job status and performance. *Hilander Foods*, 348 NLRB at 1203. For example, the Board looks to whether the employees at each facility share common supervision, as well as to where decisions are made on issues such as hiring, assignment, discipline, evaluation, and grievances. *Id.* Centralization in some matters

⁴ The parties' only dispute regarding office specialists is whether to include in the unit the office specialists who work for St. Francis Home Care Services, Inc., St. Francis Hospital Certified Home Health Services, and the preschool. Similarly, the parties' only dispute regarding administrative assistants is whether to include in the unit the one administrative assistant who works for St. Francis Hospital Certified Home Health Services.

does not rebut the single-facility presumption if significant local autonomy exists as to day-to-day issues. *Id.*; *New Britain Transp.*, 330 NLRB at 397.

Local-level supervisors at HCS have meaningful autonomy over day-to-day employment matters such as hiring, assignments, evaluations, and discipline. Moreover, the home-health aides do not share common supervision over such matters with Hospital employees. Home-health aides are directly supervised by RNs, who are supervised by nurse managers. Both the RNs and the nurse managers work at the HCS office and are paid by HCS rather than the Hospital. The nurse managers have the ultimate authority over hiring. Job candidates apply directly to HCS, after which a nurse manager will interview the applicant, administer a skills test, and make a final decision. Once hired, home-health aides receive their assignments from an HCS scheduler. If a home-health aide has a question or concern on the job, the aide speaks to an HCS RN. The RNs and nurse managers also approve or reject leave requests and conduct job appraisals. They independently issue discipline up to a first written warning. Decisions to issue discipline above that level are discussed with, but rarely reversed by, the Hospital's central HR office.

The arrangement at CHHS is similar. The three home-health aides at CHHS are supervised by RNs or the manager of clinical services, both of whom work only for CHHS. Although the Hospital's HR office has some involvement early in the process, CHHS Administrator Barbara Good has the final say on hiring. Because CHHS employs only a small number of aides, hiring is infrequent. The CHHS home-health aides receive assignments from the CHHS administrative assistant.⁵ CHHS supervisors provide orientation, answer on-the-job questions, approve leave requests, and issue

⁵ The record does not contain the name of the administrative assistant at CHHS.

discipline up to a first written warning. The Board has upheld the single-facility presumption under similar circumstances. See, e.g., *D&L Transp., Inc.*, 324 NLRB 160, 161 (1997) (finding a single-facility unit appropriate when local supervisors handled hiring, assignment, time off, and minor discipline, but formal discipline had to be discussed with and approved by headquarters).

The record contains some evidence of centralized administration. Barbara Good, the administrator for both HCS and CHHS, reports to the Hospital's Vice President of Nursing Services Barbara Naru, for example. Senior Hospital administration, including Vice President for Human Resources George Prisco, approves HCS's annual budget and establishes the wage ranges for HCS employees. In addition, as discussed below, home-health aides are subject to some of the same personnel policies as Hospital employees. However, such high-level centralization does not outweigh the local autonomy over day-to-day matters described above. See *Hilander Foods*, 348 NLRB at 1203; *New Britain Transp.*, 330 NLRB at 397; see also *Fraser Eng'g Co.*, 359 NLRB No. 80, slip op. at 9 (March 20, 2013) (discounting the fact that "employees share common supervision at the highest level," because "the two groups of employees are separately supervised at the first and second levels by different managers and assistant managers").

The Hospital, in its post-hearing brief, relies on *West Jersey Health System*, 293 NLRB 749 (1989), and *St. Luke's Health System*, 340 NLRB 1171 (2003), but both cases are distinguishable. The degree of centralized control in *West Jersey* was significantly greater, with a system-wide departmental director responsible for hiring, discipline, assignments, and evaluations at each of the employer's facilities. 293 NLRB

at 750. Here, although the Hospital's HR office handles a variety of personnel matters for HCS and CHHS, it does not have final say on hiring decisions like the centralized HR office in *St. Luke's*. 340 NLRB at 1173.

B. Similarity of Employee Skills, Functions, and Working Conditions

The similarity of skills, functions, qualifications, and terms and conditions of employment among employees at multiple facilities is a relevant consideration as to whether a single-facility unit is appropriate. *Novato Disposal Servs., Inc.*, 328 NLRB 820, 820 (1999).

With the exception of sitters, discussed below, the Hospital does not contend that home-health aides and Hospital employees share common skills or perform common functions. These two groups of employees work in different settings: the petitioned-for employees work in the Hospital, while the home-health aides typically work in patients' homes or in the HCS and CHHS offices. Because HCS has other clients besides the Hospital, the home-health aides work with both Hospital and non-Hospital patients. CHHS employees do not work in the Hospital.

Home-health aides and Hospital employees share some of the same terms and conditions of employment; both groups of employees are subject to Hospital personnel policies regarding issues such as sick leave, attendance and punctuality, discipline, sexual harassment, and grievance processing, for example. Shared personnel policies do not necessarily render a single-facility unit inappropriate, however. *See Hilander Foods*, 348 NLRB at 1200, 1203. Moreover, differences in terms and conditions also exist. Home-health aides must meet additional requirements, such as passing a criminal-background check because they work in patients' homes. Unlike Hospital

employees, home-health aides rarely have on-site supervision. The home-health aides are paid weekly, while Hospital employees are paid every two weeks.

The exception to the general absence of evidence of common skills and functions is the position of sitter, which exists at both HCS and the Hospital.⁶ HCS sitters and the Hospital sitters perform similar functions and share similar skills, as established by their written job descriptions. Despite their similarity in skills and functions, HCS home-health sitters and Hospital sitters do not share common working conditions. For example, Hospital sitters work regular eight-hour shifts, while home-health sitters work on an as-needed basis with highly variable hours. A home-health aide's time with a patient on a given day could range from 2 to 24 hours, depending on the patient's needs. In addition, HCS home-health sitters also work for non-Hospital clients at numerous other locations and report to different supervisors. The home-health aides are paid at a different pay grade than Hospital sitters, and are paid weekly rather than biweekly.

The sitter position at both HCS and the Hospital may have common skills and functions, but, as noted, the record also discloses significant dissimilarities in the two types of sitters' terms and conditions. Moreover, it is just one position among many at both facilities. I find that the evidence of common skills and function in this one position is insufficient, by itself, to rebut the presumption of appropriateness of a single-facility unit, especially when weighed against the countervailing evidence of dissimilarity in the two types of sitters' terms and conditions of employment and the lack of evidence of similar skills or function in other Hospital and HCS positions.

⁶ The specific sitter classifications at HCS are the sitter and sitter/homemaker titles, and at the Hospital the hospital care aide (sitter) title. CHHS does not employ any sitters.

C. Employee Interchange or Interaction; Functional Integration

Evidence of employee interchange between facilities can rebut the single-facility presumption. *New Britain Transp.*, 330 NLRB at 397. The party opposing a single-facility unit on grounds of employee interchange must show that the interchange involves a significant portion of the workforce and that the transferred employees report to the transferee facility's supervisors while working there. *Id.* at 398. In its interchange analysis, the Board considers evidence of temporary, mandatory transfers between facilities to be more significant than evidence of permanent or voluntary transfers. *Id.*; *Red Lobster*, 300 NLRB 908, 911 (1990). A party must present its evidence of interchange in context, explaining what percentage of employees or work the evidence represents. *Dunbar Armored, Inc. v. NLRB*, 186 F.3d 844, 849 n.5 (7th Cir. 1999); *New Britain Transp.*, 330 NLRB at 398; *Courier Dispatch Group*, 311 NLRB 728, 731 (1993).

The only record evidence of employee interchange involves HCS home-health aides who work as sitters in the Hospital when the Hospital cannot fill all of the shifts with Hospital sitters.⁷ When it needs additional sitters, the Hospital asks HCS to supply employees to fill in; the Hospital pays HCS for the use of these employees. When working as Hospital sitters, home-health aides receive Hospital-sitter wages and report to Hospital supervisors. Home-health aides combine their hours worked as Hospital sitters with their hours worked as home-health aides to determine if they earned overtime wages for working more than forty hours in a week.

Weighing against the significance of this evidence is the record's suggestion that the interchanges were voluntary. See *New Britain Transp.*, 330 NLRB at 398.

⁷ The specific HCS classifications that fill in as sitters at the Hospital include home-health aides, personal care aides, and sitter/homemakers.

Administrator Good testified that some home-health aides liked working as Hospital sitters and thus did so often, and that others came to the Hospital only infrequently, which suggests that the home-health aides can choose whether to work as Hospital sitters when the opportunity arises. In addition, the fact that the Hospital pays HCS for the use of home-health aides as sitters suggests that the home-health aides are acting more as contract employees than transfers. The Hospital seeks out home-health aides to work as sitters only when no Hospital sitters are available, and does not regularly use home-health aides for any other position besides sitter. Further, the record contains no evidence of interchange in the other direction; no Hospital employees work as home-health aides. Finally, the record contains no evidence of interchange between CHHS home-health aides and the Hospital.

The data that the Hospital offers in support of its interchange argument are somewhat unclear. The Hospital presented a chart showing the number of times that a home-health aide worked as a Hospital sitter in the first six months of 2013, but this chart does not show the percentage of home-health aides who worked as Hospital sitters or the percentage of Hospital-sitter shifts worked by home-health aides. The Hospital also presented documents entitled "Patient Schedule List," from which it derived the chart information. While these documents list the names of the HCS employees who fill in as Hospital sitters and the shifts they worked in 2011, the list does not include the number of shifts worked by Hospital sitters during the same period of time. Thus, the list, like the summary chart, does not provide contextualizing

information.⁸ Instead, these documents present the type of aggregate data that the Board has rejected as insufficient to rebut the single-facility presumption. See *New Britain Transp.*, 330 NLRB at 398 (finding that the employer's evidence of interchange did not rebut the single-facility presumption because it did not reveal "the percentage of the total number of routes and charters involving temporary interchange or the percentage of the total employees involved in temporary interchange").

Similarly, although the record also shows that home-health aides can apply for permanent positions at the Hospital, the Hospital did not provide evidence of how often this occurs. In any event, the Board affords less weight to permanent transfers as evidence of interchange, especially when they are voluntary. *D&L Transp., Inc.*, 324 NLRB at 162 n.7; *Red Lobster*, 300 NLRB at 911.

The Hospital cites *St. Luke's* for support, but the evidence of interchange in that case was more extensive and more specific. Here, the only interchange is HCS home-health aides substituting for Hospital sitters; no Hospital employees work at HCS or CHHS. In *St. Luke's*, by contrast, several different types of employees travelled between facilities, and the interchange was reciprocal. 340 NLRB at 1173. Moreover, in that case, several of the employees who travelled between facilities were "float" employees who had no home base. *Id.* There was no suggestion in *St. Luke's* that, as here, the transferee facility compensated the transferring facility for the use of its employees. Further, the record in that case showed both the number of permanent transfers and the percentage of employees engaged in temporary transfers. *Id.*

⁸ The Hospital attached a similar patient schedule list to its post-hearing brief that covers the period from January 2012 to July 2013. This document was not entered into evidence at the hearing and thus is not part of the record. The Hospital refers to this document as Exhibit 4 from the hearing, but the two documents are different. Accordingly, I will disregard it. Even if I were to consider it, the information in the 2012-2013 list lacks context in the same manner as the 2011 list and thus adds little probative value.

The Hospital has not provided evidence of functional integration that would rebut the single-facility presumption. Operations at multiple facilities are functionally integrated when the employees at the various sites all participate meaningfully in a single work process. Some home-health aides may conceivably participate in the same process as the Hospital employees if the client receiving home-health care is a discharged Hospital patient, but the record has no evidence as to what kind of coordination, if any, occurs between the two groups of employees in such situations. Moreover, any such coordination would be limited to a subset both of patients receiving home-health care and of HCS work. The Hospital contracts with HCS to provide home-health services to its patients, but has similar contracts with other home-care providers, such as Will Care Anytime and Comprehensive Home Care. HCS also has its own clientele, contracting with other entities besides the Hospital and with individuals to provide homecare. Indeed, less than half of HCS's home-health clients are former Hospital patients. Sixty percent of HCS's business is with private individuals; the remaining forty percent is split among the Hospital and five other institutional clients. *See Visiting Nurses Ass'n*, 324 NLRB at 55 (in concluding that the petitioned-for home-health provider's RNs, excluding the RNs at an affiliated hospital, were an appropriate single-location unit, Board found that the fact that 25-30 percent of the home-health provider's patient referrals came from sources other than the hospital supported the single-facility presumption). Home-health aides would work with Hospital employees and patients if they are filling in as Hospital sitters, but, as discussed above, the incidence of this situation is uncertain and pertains only to those HCS home-health aides who sometimes work as Hospital sitters.

Finally, the Hospital has not presented evidence as to the degree of interaction, if any, between home-health aides and Hospital employees who are included in the unit. The physical separation and lack of integration suggests that it would be minimal.

D. Geographic Location

Geographic separation weighs in favor of a single-facility unit, especially when other factors also support the single-facility presumption. *New Britain Transp.*, 330 NLRB at 398. HCS's and CHHS's offices are approximately seven miles away from the Hospital. Moreover, home-health aides spend almost all of their working hours in patients' homes; they report to the office only occasionally, such as to pick up supplies. Although the majority of HCS home-health aides' work is for patients who live in Dutchess County, they are also licensed to work in eight surrounding counties. Even if the home-health aides worked out of the office, the distance between that office and the Hospital supports the presumption of appropriateness of a single-facility unit at the Hospital under the circumstances presented here. *See id.* (finding a distance of six miles between facilities significant when other factors supported a single-facility unit); *Cargill, Inc.*, 336 NLRB 1114, 1114 (2001) (finding appropriate a single-facility unit when another facility was two miles away).

E. Bargaining History

The absence of bargaining history is a neutral factor in the analysis of whether a single-facility unit is appropriate. *Trane*, 339 NLRB 866, 868 n.4 (2003). The Hospital cites *St. Luke's* for the proposition that a lack of bargaining history supports rebuttal of the single-facility presumption, but that case does not stand for such a proposition.

Thus, the fact that there is no bargaining history here neither supports nor undermines the appropriateness of the petitioned-for unit.

Conclusion: Home-Health Aides

Considered in light of the factors described above, the evidence in the record does not rebut the presumption of appropriateness that attaches to the petitioned-for single-facility unit. The home-health aides and Hospital employees have separate supervision and separate control over day-to-day employment matters, their work is not functionally integrated, and there is little evidence of interaction. Their work sites are geographically separate. Although the Hospital presents some evidence of employee interchange, the interchange appears to be voluntary and is more in the nature of contract work than transfer; moreover, the scope and frequency of the interchange is difficult to glean from the record. One home-health position is similar in function and skill to one Hospital position, but some of the terms and conditions related to these two positions differ. Ultimately, the evidence that would favor a multi-facility unit is outweighed by the evidence that supports a single-facility unit. The Hospital thus has not met its burden to rebut the single-facility presumption, and I conclude that the home-health aides should be excluded from the petitioned-for unit.

II. Teaching Assistants

Approximately 19 teaching assistants work at the preschool, and approximately 26 work at the daycare. As noted above, the preschool is run by St. Francis Preschool, Inc, a separate corporation from the Hospital; the record is unclear whether the daycare is run by St. Francis Preschool, Inc. or the Hospital. The daycare and preschool are

both separately licensed from the Hospital. Teaching assistants at both operations are on the Hospital payroll.

The daycare provides basic childcare services for children up to five years old. Many, but not all, of the children in the daycare program are children of Hospital employees. The daycare has two sites, one in a separate building on the Hospital campus⁹ and the other four miles away. The on-campus daycare facility cares for approximately 35 children. The off-campus daycare facility cares for more than 100 children. The preschool provides special-education services and speech, occupational, and physical therapy for children who qualify for such services under county regulations. The three preschool sites are located off-campus, at distances ranging from 4 to 13 miles away from the Hospital. Teaching assistants at both the daycare and the preschool attend to the daily needs of children in the program, including classroom activities, feeding, napping, toileting, and safety.

A. Central Control of Daily Operations and Labor Relations

The teaching assistants do not share common supervision with other Hospital employees in their day-to-day work. Instead, a distinct management structure exists within the daycare and preschool departments. Teaching assistants are supervised by the teachers whom they assist, and by a site director at the school. Site directors also handle day-to-day matters like job assignments and leave requests. If a teaching assistant has to miss work, for example, the site director finds a replacement. The directors also arrange for teaching assistants who normally work at one site to work at a different site if that site needs additional support. Low-level discipline, such as a

⁹ The on-campus day care facility is physically connected to the Hospital.

coaching, is handled by the on-site supervisors. Although daycare and preschool supervisors must consult with the Hospital's central HR office before issuing high-level discipline such as a written warning or a suspension, HR has never told those supervisors not to take a recommended disciplinary action.

Although the Hospital's centralized HR department formally hires teaching assistants, it does so with the recommendation of Margaret Slomin, the preschool and daycare director. After HR interviews an applicant, a daycare or preschool supervisor conducts a second interview and makes a recommendation. HR will hire the applicant if both HR and the daycare or preschool department agree that he is worthy. Slomin testified that HR has never declined to hire an applicant that she recommended. Newly hired teaching assistants attend one day-long orientation with other new Hospital employees, but also receive on-the-job and in-service training within the daycare or preschool department. They are subject to both Hospital-wide and department-specific policies.

The Hospital approves an annual budget and salaries, and central HR sets the salary scale. As described above, however, high-level centralization does not outweigh local autonomy over day-to-day matters in the single-facility-presumption analysis. See *Fraser Eng'g Co.*, 359 NLRB No. 80; *Hilander Foods*, 348 NLRB at 1203. Such autonomy exists at the daycare and preschool. See *D&L Transp., Inc.*, 324 NLRB at 161.

B. Similarity of Employee Skills, Functions, and Working Conditions

The similarity or dissimilarity of work, qualifications, working conditions, wages and benefits among employees at issue herein have some bearing on determining the

appropriateness of the single-facility unit. However, as noted above, this factor is less important than whether individual facility management has autonomy and whether there is substantial interchange. See, e.g., *Dattco, Inc.*, 338 NLRB at 51.

The Hospital has not shown that there are petitioned-for Hospital positions that share the same skills or functions as the teaching assistants. The record contains little evidence from which to compare the terms and conditions of employment for the teaching assistants and Hospital employees. The teaching assistants are subject to the same or similar Hospital-wide attendance, disciplinary, safety and confidentiality/HIPPA policies as the petitioned-for employees. By contrast, some teaching assistants are required to satisfy a variety of certification and training requirements from the state Office of Children & Family Services that other employees do not have to meet.

C. Employee Interchange or Interaction; Functional Integration

The Hospital does not present any evidence of temporary interchange between teaching assistants and Hospital employees. Teaching assistants do not work in the Hospital, and Hospital employees do not work in the daycare or the preschool. Although a few teaching assistants have taken jobs in the Hospital, the Board does not consider such voluntary, permanent interchanges to be as relevant as temporary interchanges for the single-facility-presumption analysis. *Red Lobster*, 300 NLRB at 911. Moreover, the record does not reveal how often these permanent interchanges occur. The Hospital's evidence of employee interchange between daycare and preschool sites, or between the daycare and the preschool, is not relevant to the issue of whether the teaching assistants should be included in the unit; interchange between

two groups of employees that are not in the unit does not create a community of interest between those employees and unit employees.

Similarly, the record contains no evidence of functional integration of the daycare and preschool with the Hospital. In addition to the physical separation between most of the daycare and preschool sites and the Hospital, the teaching assistants do not participate in any common work processes or operations with employees in other departments. The fact that many of the children in the daycare are children of Hospital employees does not constitute functional integration between the daycare and the Hospital. The Hospital asserts that the daycare is necessary for the Hospital to function because it enables Hospital employees to come to work, but has not shown that alternative childcare options do not exist.

The record has some evidence of interaction between teaching assistants and other Hospital employees. Employees from the Hospital's food-services department work in the kitchen at one preschool site, for example. The Hospital's environmental-services personnel work at some of the daycare and preschool sites, but the record does not reveal what kind of services they perform there. One of the preschool sites is housed in a building that also includes offices for the Hospital's audiology and speech departments. However, the record does not show whether any interaction occurs between employees in the various departments at that site.¹⁰ This evidence is not sufficient by itself to outweigh the lack of interchange or functional integration.

¹⁰ The record does not indicate whether there are any petitioned-for classifications in the audiology and speech departments at that location.

D. Geographic Location

The three preschool sites are respectively located 4, 4, and 13 miles away from the Hospital. One daycare site is located on the main Hospital campus, but the other site is four miles away. The off-campus daycare site is larger, serving two to three times as many children as the on-campus site. Moreover, the Board has held that a single-facility unit can be appropriate even if it excludes employees who work at other facilities on the same campus if the facilities house distinct operations with their own clients and staff. See *Visiting Nurses Ass'n*, 324 NLRB at 59; *Passavant Ret. & Health Ctr., Inc.*, 313 NLRB 1216, 1218 (1994). Such distinctions are present here. When considered in light of the other factors, such as the lack of common supervision or employee interchange, the geographic proximity of some of the work sites to the Hospital does not weigh strongly in favor of including the teaching assistants in the unit. *New Britain Transp.*, 330 NLRB at 398.

E. Bargaining History

No bargaining history exists, which is a neutral factor in the analysis of whether the single-facility presumption has been rebutted. *Trane*, 339 NLRB at 868 n.4.

Conclusion: Teaching Assistants

Having evaluated the record in light of the factors in the single-facility-presumption analysis, I conclude that the teaching assistants should be excluded from the unit found appropriate herein. The Hospital has presented no evidence of employee interchange, shared skills, or functional integration. The record has some evidence of centralized control, but also shows local autonomy on a variety of day-to-day employment matters. The geographic proximity of some the sites to the Hospital

provides some support for a multi-facility unit, but is counterbalanced by the evidence supporting a single-facility unit. The Hospital has not met its burden to rebut the single-facility presumption.

CONCLUSIONS AND FINDINGS

Based upon the entire record in this matter and in accordance with the discussion above, I find and conclude as follows:

1. The hearing officer's rulings are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction herein.

3. The Petitioner is a labor organization within the meaning of Section 2(5) of the Act and claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

5. The following employees¹¹ of the Employer constitute a unit appropriate for the purpose of collective bargaining within the meaning of Section 9(b) of the Act:

All full-time, part-time, and per diem service and maintenance workers employed by the Hospital at its facility at 241 North Road, Poughkeepsie, New York, including administrative assistant, cafeteria aide, cancer registry assistant, cardio diagnostic tech, central services technician, chemical dependency counselor I, chemical dependency counselor II, chemical dependency counselor sr., chemical dependency

¹¹ The parties have stipulated that per-diem employees will be included in the unit if they worked an average of four hours per week in the calendar quarter preceding the eligibility date. Based on the parties' stipulation, which is consistent with the Board's test in *Arlington Masonry Supply, Inc.*, 339 NLRB 817 (2003), I shall include all regular part-time and per-diem employees in the bargaining unit found appropriate herein.

therapist I, clerk/phlebotomist, cook, coordinator-guest services, coordinator-office I, coordinator-nursing service staffing, coordinator-scheduling, customer service rep I, customer service rep II, EAP assistant, employee health assistant, environmental services aide, gift shop associate, group leader-SPD, guest services representative, hospital care aide (sitter), hospital driver I (no CDL license), intake specialist, inventory control clerk I, inventory control clerk II, mailroom associate, mammography assistant, master printer, materials/rec/dist clerk I, medical assistant, medical office assistant, medical office assistant I, medical office assistant II, medical receptionist, monitor technician, nutrition aide, nutrition clerk, office coordinator II, patient care technician, patient family liaison, pharmacy technician II, pharmacy technician III, physical therapy aide, radiology technician assistant, radiology technician staff, rehab services specialist, resource center associate, trauma services specialist, transporter, unit secretary, unit secretary/PCT, valet/parking attendant, and office specialist; excluding clinical information liaison, clinical applications analyst, coordinator-CDM/financial services, coordinator-cancer program, coordinator-patient registration, financial applications analyst, foundation assistant, coordinator-radiology financial services, customer service assistant, surgical services inventory/charge master specialist, lead help desk operator, patient billing specialist, PC support technician, medical biller, medical records assistant/librarian, medical records representative II, coordinator-intake, HR office assistant, home-health aide, home-health aide II (LHC), licensed homemaker, licensed live-in, patient-care scheduler (LHC), personal care aide, personal care aide (LHC), sitter (at St. Francis Home Care Services, Inc.), sitter/homemaker, community liaison, teaching assistant, clinical education aide, administrative assistant (at St. Francis Hospital Certified Home Health Services), office specialist (at St. Francis Home Care Services, Inc., St. Francis Hospital Certified Home Health Services, and the preschool), managers, guards, and all professional employees and supervisors as defined in the Act.

There are approximately 524 employees in the unit found appropriate herein.

DIRECTION OF ELECTION

The National Labor Relations Board will conduct a secret ballot election among the employees in the unit found appropriate above. Employees will vote whether or not

they wish to be represented for purposes of collective bargaining by **1199 SEIU, United Healthcare Workers East**. The date, time and place of the election, will be specified in the Notice of Election which will issue shortly.

A. Voting Eligibility

Eligible to vote in the election are those in the unit who were employed during the payroll period ending immediately before the date of this Decision, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Employees engaged in any economic strike, who have retained their status as strikers and who have not been permanently replaced are also eligible to vote. In addition, in an economic strike which commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as strikers but who have been permanently replaced, as well as their replacements are eligible to vote. Unit employees in the military services of the United States may vote if they appear in person at the polls.

Ineligible to vote are (1) employees who have quit or been discharged for cause since the designated payroll period; (2) striking employees who have been discharged for cause since the strike began and who have not been rehired or reinstated before the election date; and (3) employees who are engaged in an economic strike that began more than 12 months before the election date and who have been permanently replaced.

B. Employer to Submit List of Eligible Voters

To ensure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should

have access to a list of voters and their addresses, which may be used to communicate with them. *Excelsior Underwear, Inc.*, 156 NLRB 1236 (1966); *NLRB v. Wyman-Gordon Company*, 394 U.S. 759 (1969).

Accordingly, it is hereby directed that within 7 days of the date of this Decision, the Employer must submit to the Regional Office an election eligibility list, containing the full names and addresses of all the eligible voters. *North Macon Health Care Facility*, 315 NLRB 359, 361 (1994). The list must be of sufficiently large type to be clearly legible. To speed both preliminary checking and the voting process, the names on the list should be alphabetized (overall or by department, etc.). This list may initially be used by me to assist in determining an adequate showing of interest. I shall, in turn, make the list available to all parties to the election.

To be timely filed, the list must be received in the Regional Office on or before **August 22, 2013**. No extension of time to file this list will be granted except in extraordinary circumstances, nor will the filing of a request for review affect the requirement to file this list. Failure to comply with this requirement will be grounds for setting aside the election whenever proper objections are filed. The list may be submitted to the Regional Office by electronic filing through the Agency's website www.nlr.gov, by mail, by hand or courier delivery, or by facsimile transmission at 716-551-4972. To file the eligibility list electronically, go to the Agency's website at www.nlr.gov, select **File Case Documents**, enter the NLRB Case Number, and follow the detailed instructions. The burden of establishing the timely filing and receipt of the list will continue to be placed on the sending party.

C. Notice of Posting Obligations

According to Section 103.20 of the Board's Rules and Regulations, the Employer must post the Notices to Election provided by the Board in areas conspicuous to potential voters for at least 3 working days prior to 12:01 a.m. of the day of the election. Failure to follow the posting requirement may result in additional litigation if proper objections to the election are filed. Section 103.20(c) requires an employer to notify the Board at least 5 full working days prior to 12:01 a.m. of the day of the election if it has not received copies of the election notice. *Club Demonstration Services*, 317 NLRB 349 (1995). Failure to do so estops an employer from filing objections based on nonposting of the election notice.

RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street, N.W., Washington, DC 20570-0001. This request must be received by the Board in Washington, DC by 5 p.m. EDT **August 22, 2013.**

The request may be filed electronically through the Agency's web site, www.nlr.gov,¹² but may not be filed by facsimile.

DATED: August 8, 2013

/s/Rhonda P. Ley
RHONDA P.LEY, Regional Director
Region 3
National Labor Relations Board
Region 3
130 S Elmwood Ave., Suite 630
Buffalo, NY 14202-2387

¹² Filing a request for review electronically may be accomplished by using the E-filing system on the Agency's website at www.nlr.gov. Once the website is accessed, select **File Case Documents**, enter the NLRB Case Number, and follow the detailed instructions. The responsibility for the receipt of the request for review rests exclusively with the sender. A failure to timely file the request for review will not be excused on the basis that the transmission could not be accomplished because the Agency's website was off line or unavailable for some other reason, absent a determination of technical failure of the site, with notice of such posted on the website.