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

FRED & HARRIETT TAYLOR HEALTH CENTER

Employer

and

Case 03-RC-115208

1199 SEIU UNITED HEALTHCARE WORKERS EAST

Petitioner

DECISION AND DIRECTION OF ELECTION

The Employer operates a skilled-nursing facility which shares some services with, and is physically connected to Ira Davenport Memorial Hospital, Inc. ("IDMH"), an acute care hospital.[1] IDMH is part of the Arnot Health System ("AHS"). Arnot Ogden Medical Center and St. Joseph's Hospital, both located in Elmira, New York, are also in the AHS system. The Petitioner seeks to represent a unit of certified nursing assistants ("CNAs") and licensed practical nurses ("LPNs") employed by the Employer.[2]

The parties disagree as to the scope of the unit and the applicable Board law. The Employer contends that the Employer and IDMH constitute a single facility, and therefore, consistent with the Board's rules for acute-care facilities ("Health Care Rule" or "Rule"), the only appropriate unit is a combined unit of the Employer's and IDMH's service and maintenance employees, and a combined unit of the Employer's and

[1] The Petitioner and the Employer disagree as to the correct name of the Employer. The record demonstrates that the Employer is an incorporated entity that does business as and is commonly known as Fred & Harriet Taylor Health Center. I do not make a finding as to the proper legal name of the skilled nursing facility as it is not dispositive of the issues raised herein, but for purposes of this decision, "Employer" refers to the Fred & Harriet Taylor Health Center.

[2] In its brief, the Petitioner contends that it would proceed to an election in a unit consisting of LPNs and CNAs employed by the Employer, the CNAs that work as Unit Coordinators and Activity Aides, and, LPNs and CNAs that work in Adult Day Care, if such unit were found appropriate. The Petitioner will not agree to include the non-CNA Activity Aides, Environmental Aides, Diet Technicians, Critical Care Coordinators that work at the Employer, or any other employee working at IMDH.

IDMH's technical employees. In the event that I find that the Employer constitutes an appropriate single facility and that the Health Care Rules do not apply, the Employer alternatively contends that additional classifications should be included in the unit.

The Petitioner contends that the Employer constitutes a single facility, and therefore the Health Care Rule does not apply. The Petitioner further contends that a unit of CNAs and LPNs within the Employer is an appropriate unit.

As discussed below, I find that the Employer constitutes a single facility and that the petitioned-for unit is appropriate.

I. The Employer constitutes an appropriate single facility.

A. Board Law

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).

In determining whether the single-facility presumption has been rebutted, the key consideration for determining the presence of central control of daily operations and labor relations is whether meaningful local autonomy exists over day-to-day matters regarding job status and performance. *Hilander Foods*, 348 NLRB at 1203. 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 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.

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). However, this factor is less important than whether individual facility management has autonomy and whether there is substantial interchange. See, for example, *Dattco, Inc.*, 338 NLRB 49, 51 (2002) ("This level of interdependence and interchange is significant and, with the centralization of operations and uniformity of skills, functions and working conditions is sufficient to rebut the presumptive appropriateness of the single-facility unit."). As a part of this analysis, the Board views evidence of functional integration as particularly relevant to the issue of whether a

single-facility unit is appropriate. Functional integration refers to when employees at two or more facilities are closely integrated with one another functionally notwithstanding their physical separation. *Wecare Transportation, LLC,* 353 NLRB 65 (2008); *Budget Rent A Car Systems,* 337 NLRB 884 (2002). Thus, functional integration involves employees at the various facilities participating equally and fully at various stages in the employer's operation, such that the employees constitute integral and indispensable parts of a single work process. Id. An important element of functional integration is that the employees from the various facilities have frequent contact with one another.

In determining whether there is sufficient employee integration to rebut the single facility presumption, the Board relies on the degree to which employees transfer between facilities, and particularly on evidence of temporary transfers. *Mercy Medical Center San Juan,* 344 NLRB 790, 793 (2005). There must be evidence that a significant portion of the workforce is involved and that the workforce is actually supervised by the local branch to which they are not normally assigned in order to meet the burden of proof on the party opposing the single-facility unit. *New Britain Transportation Co.*, 330 NLRB 397, 398 (1999). For example, the Board found that interchange was established and significant where during a 1-year period there were approximately 400 to 425 temporary employee interchanges among 3 terminals in a workforce of 87 and the temporary employees were directly supervised by the terminal manager from the terminal where the work was being performed. *Dayton Transport Corp.* 270 NLRB 1114 (1984). On the other hand, where the amount of interchange is unclear both as to scope and frequency because it is unclear how the total amount of

interchange compares to the total amount of work performed, the burden of proof is not met. *Courier Dispatch Group*, 311 NLRB 728, 731 (1993). Also important in considering interchange is whether the temporary employee transfers are voluntary or required, the number of permanent employee transfers and whether the permanent employee transfers are voluntary. *New Britain Transportation Co.*, supra, *Red Lobster,* 300 NLRB 908, 911 (1990) (degree of interchange is diminished because it was voluntary). A showing of interchange requires evidence of employees moving between one facility and another, not merely evidence of employees moving from one facility to another. See *D&L Transportation,* 324 NLRB 160,161 (1997).

B. Application of Board Law to this Case

I find that the Employer has failed to rebut the presumption that the Employer constitutes an appropriate single facility. In rejecting the Employer's argument that the relationship between the Employer and IDMH necessitates a finding that the only appropriate unit includes employees from both facilities, I rely on the following analysis and record evidence, as well as the case law referenced above:

1. Central Control of Daily Operations and Labor Relations

The record herein demonstrates that the Employer's control of daily operations and labor relations favors the single-facility presumption.

The Employer has three units: two on its lower level, where residents with increased care needs reside, and one on its upper level, where residents with lesser care needs reside. There are three shifts within each unit: day, evening and overnight.[3]

The Employer employs CNAs, who are responsible for the hands-on care of the nursing facility's residents.[4] CNAs assist the residents with their activities of daily living,

[3] The record does not contain either the beginning or end times of the shifts.

which include bathing, toileting and eating, and are primarily responsible for transporting residents in the facility. Within each unit, four or five CNAs staff the day shift, three or four staff the evening shift, and two staff the overnight shift.

The Employer also employs LPNs, who are responsible for providing medications and certain medical treatments to residents. LPNs are responsible for assigning work to the CNAs.[5] Within each unit, one LPN staffs each shift.

Registered Nurse ("RN") supervisors are the first-line supervisors for CNAs and LPNs at the Employer. Employer employees who are sick or who otherwise seek time off contact the on-duty RN supervisor. RN supervisors are notified if an employee needs to leave during a shift. RN supervisors are consulted in employee evaluations. The Employer employs three dedicated RN supervisors, two who work 12-hour rotating shifts, and one who works the overnight shift five nights a week. When none of the dedicated RN supervisors is scheduled, employees contact that the IDMH RN supervisor if they need to call off or put in a leave request, or if there is a clinical or staffing issue that needs to be resolved immediately. The Employer is planning to hire a fourth dedicated RN supervisor.[6]

IDMH and the Employer each employ an Assistant Director of Nursing ("ADON") and a Director of Nursing ("DON"). Employer LPNs report directly to the Employer's ADON. The Employer's ADON writes employee evaluations after consulting with the RN supervisor. The evaluation affects employee compensation. The Employer's DON is responsible for some employee disciplines. The ADON notifies the DON of minor

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[4] IDMH does not formally employ any CNAs. IDMH employs two clinical assistants that maintain CNA certifications.

[5] Neither party asserts that LPNs are supervisors under Section 2(11) of the Act.

[6] While the testimony is unclear, it appears from the record that the Employer intends by April or May of 2014 that there will always be an RN supervisor on staff in the skilled nursing facility.

infractions such as tardiness or excessive absences, and the DON independently decides whether to issue a low-level discipline. The DON requires approval from Human Resources for suspensions or terminations. Each DON reports to the president and chief operating officer of IDMH. The record contains no evidence indicating that the president and chief operating officer exert any day-to-day supervisory authority over RNs or LPNs.

Both IDMH and the Employer each employ a scheduler whose responsibility it is to schedule staff. Some employee time-off requests go directly to the scheduler and are ultimately approved by the DON.

New employees hired by the Employer and IDMH attend the same new-hire orientation. The Employer additionally provides a separate training that all of its new hires are required to attend. The Employer offers in-service presentations approximately once a month, which are attended only by the Employer's employees. Employer employees do not regularly receive notification about other in service presentations at IDMH.

The record contains some evidence of centralized administration. There is a single Director of Human Resources ("HR Director"), who oversees a single Human Resources Department that services all IDMH and Employer employees. The HR Director is responsible for all high level disciplines such as suspensions and terminations. Employer and IDMH employees are subject to the most of the same personnel policies. The employee handbook applies to all employees equally, and all employees are eligible for the same benefits, including paid time off, health and life insurance and a 401(k). However, the record demonstrates that the Employer

maintains some of its own policies, including policies regarding call-ins, weekend coverage, and use of paid time off. Payroll for all Employer and IDMH employees is processed at a central location.

Notwithstanding some evidence of centralized control, the record demonstrates no evidence that any IDMH supervisor is regularly involved in the day-to-day supervision of the employees in the petitioned-for unit. Rather, the record demonstrates that the Employer's DON, ADON and the RN supervisors exercise substantial control over the daily operations of the Employer's CNAs and LPNs. Thus, I find that the limited evidence of centralized control does not outweigh the significant 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").

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

While the employees of the Employer and IDMH both work in the same building, I find that the record reflects that they utilize different skills and work in very different settings under different working conditions.

Employer employees work at a skilled-nursing facility with 120 beds. Residents generally remain at the facility for months or years, and as such, there is minimal turnover in the resident population. The Employer's facility is the home for each resident. The employees, including the CNAs and LPNs, tend to the daily health and

welfare needs of each resident of an aging population. Employer employees assist the residents with all aspects of their life, including feeding, showering, toileting, daily activities and exercise. CNAs and LPNs are required to have specific licensing.[7]

IDMH employees work in a 38-bed acute care hospital that provides primarily outpatient care and some, short-term in-patient care for individuals of all ages. IDMH employees do not maintain the long-term health of each patient, but rather, are responsible for attending to whatever medical condition affects each patient, thereby allowing the patient to be discharged from the hospital. As such, the patient population changes on a daily basis. IDMH does not employ any full-time CNAs that perform solely CNA duties, while the Employer employs approximately 54 licensed CNAs that perform CNA duties on a daily basis. Both employ LPNs, but the LPNs at each facility have different job descriptions.

The record does reveal a high level of functional integration between the Employer and IDMH.

The Employer and IDMH have a shared business office, and common human resources and accounting departments. The two entities have a shared compliance officer and common employees that maintain medical records.

There is one time clock system for the entire facility. The only time clock in the Employer's portion of the facility is located next to the locked entrance door near the parking lot closest to the Employer. There are multiple time clocks located throughout IDMH. Any employee can use any time clock regardless of location.

[7] Licensing is required because of their patient care functions. Additionally, LPNs pass medications and must be licensed to do so.

IDMH patients and the Employer's residents share food and nutrition services. Employer residents generally eat in dining halls located at the Employer. The food for meals in the dining halls is picked up by the food and nutrition staff from the kitchen (located in IDMH), and then delivered to the Employer dining halls. The food and nutrition staff assist in meal set up and may pour drinks for the residents. The Employer's CNAs and LPNs are responsible for feeding the residents. Used plates and utensils are picked up by the food and nutrition workers and returned to the kitchen. Residents are permitted to eat at the IDMH cafeteria, and both IDMH and Employer employees utilize the cafeteria.

There are two diet technicians that share an office within the Employer. The diet technicians are involved in meal planning for IDMH patients and the Employer's residents, and in doing so, speak with the patients and residents about meals and sometimes assist in feeding the residents. One of the diet technicians assists the Employer residents, while the other usually assists IDMH inpatients and adult day-care attendees. The diet technicians assist each other as needed.

Employer LPNs make the initial attempts to draw blood from residents. If the draw is successful, the blood is sent to the IDMH laboratory (which supports both the Employer and IDMH). If the LPN is unable to successfully draw blood, the laboratory is notified and a phlebotomist comes to the Employer to draw the blood. LPNs contact the laboratory under these circumstances one or two times per week.

Employer residents that need x-rays are transported by Employer staff to IDMH. For residents that are unable to be transported, IDMH radiology technicians bring a mobile x-ray unit to the Employer's premises from IDMH.

A respiratory therapist from IDMH comes to the Employer about once a week to service a CPAP machine to assist residents having difficulty sleeping. IDMH EKG technicians come to the Employer to perform services on residents multiple times a month. IDMH rehabilitation therapists and aides come to Employer residents if the resident is unable to be transported to the rehabilitation facility. IDMH pharmacy technicians pick up prescriptions and drop off medications at the nurses' desk at the Employer on a daily basis.[8] Some Employer residents are transported to IDMH monthly for infusions. Other shared services include laundry, housekeeping and maintenance.[9]

IDMH and the Employer have separate main entrances which are generally used by the employees and visitors of the respective facilities. The Employer's employees tend to park in the lot located behind the Employer's facility, though there is no restriction on IDMH employees parking in that lot. A locked third entrance, used primarily by employees of the Employer, is located near that lot and offers direct access to the Employer.[10] IDMH employees generally park in the parking lot adjacent to the one used by the Employer's employees which is located closer to the IDMH main entrance. There is a lot located in front of the facility which is reserved for residents, patients and visitors during weekdays. Employees are only permitted to use that lot during nights and weekends.

In sum, while employees of the Employer and IDMH work in different settings and working conditions, the record evidences a substantial amount of functional

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[8] IDMH has an in-house pharmacy. Most medications for Employer residents are provided by an outside pharmacy.

[9] CNAs collect the laundry and delivers it to the Employer's utility room. Housekeeping then picks the laundry up.

[10] All exterior locked doors, and some interior locked doors within the facility can be opened with ID badges that can be used as swipe cards. Employer and IDMH employees are provided with the same badges, which can be used to open any of these doors regardless of location.

integration between the two groups, as evidenced by the frequent interactions, common administration, and shared patient and resident services. Specifically, the record reflects that Employer residents regularly interact with and are provided services by IDMH employees, and as a result, IDMH employees are often in the presence of Employer employees. However, the record fails to reveal that IDMH employees regularly perform the same tasks performed by the Employer's employees and the IDMH employees that come to the Employer's facility perform different functions than those performed by the Employer's employees. Based on the above, I find that the lack of similarity of employee skills, functions and working conditions weighs in favor of the single-facility presumption.

3. Degree of Employee Interchange

I find that the record demonstrates little evidence of meaningful employee interchange.

The record demonstrates that employees desiring a transfer must apply for an opening like any other individual. Openings are posted in human resources and on the IDMH external website. After the transfer, the employee is subject to the same 90 day probation period as any other new hire. Employee transfers between IDMH and the Employer maintain their original date of hire for seniority purposes. Over the past 15 years, six CNAs or LPNs have permanently transferred eight times between the Employer and IDMH.[11] Of those eight transfers, four were from the Employer to IDMH, and four were from IDMH to the Employer. There is no evidence to indicate what percentage of employees employed over the period of these permanent transfers had

[11] Specifically, there were two transfers in 1998; one in 2001, one in 2005, one in 2007, two in 2012, and one in 2013 (to date).

transferred. A party presenting evidence of interchange must provide a context, explaining what percentage of employees or work the evidence represents. *New Britain Transp.*, 330 NLRB at 398; *Courier Dispatch Group*, 311 NLRB 728, 731 (1993). See also *J&L Plate, Inc.*, 310 NLRB 429 (1993).

The Employer failed to provide any evidence of meaningful interchange between the Employer and IDMH. Specifically, there is no evidence of any temporary interchange between employees of IDMH and the Employer.[12] The record fails to establish that the Employer's employees are scheduled to work at IDMH, or that IDMH are placed on the schedule to work at the Employer. The only evidence of any temporary interchange is that two IDMH LPNs occasionally work per diem shifts as LPNs at the Employer. However, the record demonstrates that those employees are placed on the same per diem list and are required to complete the same Employer-provided orientation as any potential per diem LPN. Further, the record reflects that neither individual has worked for the Employer during the last several months.

The Employer has failed to establish any consistent pattern of employee interchange between the Employer and IDMH. Nearly all of limited evidence of interchange is of voluntary, permanent transfers, and therefore, is afforded less weight. *New Britain Transportation Co.*, supra, *Red Lobster*, supra. Further, the Employer failed to place the minimal evidence of interchange into context. As such, the record evidence fails to support the Employer's claim of consistent meaningful interchange. Therefore, I find that the lack of interchange supports the singe facility presumption.

[12] The Employer presented some evidence that IDMH clinical assistant Paula Sabins regularly fills in at the adult day care at the skilled nursing facility, but the record is silent as to whether she does so voluntarily or at the Employer's direction.

4. Distance Between Locations and Bargaining History

IDMH and the Employer are physically attached, with the structure resembling a rectangle with a courtyard located in the middle. IDMH occupies the South and East portions of the structure, and the Employer occupies the North and West portions of the structure. Staff members can travel from the Employer to IDMH without leaving the building. Based on the above, the close geographical proximity of the two weighs against the single facility presumption. See, e.g., *Fisher Controls Co.*, 192 NLRB 514 (1971).

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

5. Conclusion Concerning Unit Scope

I find that the Employer has failed to rebut the presumption that the petitioned-for single facility is appropriate. As noted above, separate supervision and degree of interchange are the most important factors in determining the appropriateness of a petitioned-for single-facility unit., *Heritage Park Health Care Ctr.*, supra. Here, the Employer's employees and the IDMH employees have separate and distinct supervision with separate control over day-to-day employment matters, and there is little evidence of interchange between these two groups of employees. In addition, the two groups perform different work under different conditions. Therefore, the evidence that favors a multi-facility unit, including, the apparent functional integration and the close proximity of the Employer and IDMH facilities, is outweighed by the evidence that supports a single-

facility unit. As such, I find that the Employer has failed to rebut the single-facility presumption, and I find that the Employer is a single facility.[13]

II. The Health Care Rules do Not Apply

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.

Id.

The Employer argues that the Employer and IDMH constitute a single-employer and that the Health Care Rule should apply because IDMH is an acute care hospital. The Board's Health Care Rule defines an acute care hospital as follows:

> [E]ither a short term care hospital in which over 50% of all patients are admitted to units where the average length of patient stay is less than thirty days. Average length of stay shall be determined by reference to the most recent twelve month period...for which data is readily available. The term 'acute care hospital' shall include those hospitals operating as acute care facilities even of those hospitals provide such services as, for example, long term care, outpatient care, psychiatric care or rehabilitative care, but shall exclude facilities that are primarily nursing homes, primarily psychiatric hospitals, or primarily rehabilitation hospitals.

[13] Although the Board in *Specialty Healthcare and Rehabilitation Center of Mobile*, 357 NLRB No. 83 (2011), did not indicate whether it intends to apply its analytical framework in determining whether a single-facility unit or multi-facility unit is appropriate for collective bargaining, for the reasons contained herein, I similarly find that the single location unit is appropriate under the standards set forth in that case.

54 Fed. Reg. 16336 (1989)

Due to my determination that the Employer, a skilled nursing facility, constitutes a single facility, the Employer's argument that the Health Care Rule applies to the proposed unit fails, as the Rule expressly excludes from coverage "facilities that are primarily nursing homes."

Assuming arguendo that the Employer and IDMH jointly constituted a single facility, I would nonetheless find that the Rule does not apply. The Board has described the Rule as "designed to cover the more typical free-standing acute care hospital." *Child's Hosp.*, 307 NLRB 90, 92 (1992). The record reflects that, at any one time, the combined facility primarily operates as a skilled nursing facility, as evidenced by the number of resident days at the Employer compared to the number of patient days at IDMH,[14] and the number of resident beds generally in use at the Employer compared to the number of patient beds generally is use at IDMH.[15] See *Child's Hospital*, supra, *Specialty Hospital of Washington-Hadley*, 357 NLRB No. 77 (August 26, 2011). In addition, precedent suggests that the Rule does not automatically mandate the inclusion of all employees in the same unit 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 in that same system. *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

[14] The record illustrates that from January 2012 through September 2013, IDMH admitted approximately 900 patents, with an average stay of approximately 3.5 days, while the Employer admitted approximately 260 residents with an average stay of at least 100 days. It should be noted that the Employer failed to provide documentation to definitively establish the average length of stay of each resident, though the Employer acknowledges that the average resident stay exceeds 100 days.

[15] The record reflects that, at any one time, on average, there are 107 resident beds in use at the Employer and six patient beds in use at IDMH.

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).

Therefore, I find that the Health Care Rules do not apply to the Employer.

III. The Petitioned-for Unit is an Appropriate Unit

A. Board Law

In *Specialty Healthcare and Rehabilitation Center of Mobile*, 357 NLRB No. 83 (2011), the Board overruled *Park Manor Care Center*, 305 NLRB 872 (1991), and determined that, in nonacute healthcare settings (such as a skilled nursing facility), when a union seeks to represent a unit of employees "who are readily identifiable as a group (based on job classifications, departments, functions, work locations, skills or similar factors), and the Board finds that the employees in the group share a community of interest after considering the traditional criteria, the Board will find the petitioned-for unit to be an appropriate unit...." *Specialty Healthcare*, 357 NLRB slip op. at 12. If the petitioned-for unit satisfies that standard, the burden shifts to the party seeking a larger unit to show that the additional employees share an "overwhelming" community of interest with the petitioned-for employees, such that there "is no legitimate basis upon which to exclude certain employees from" the larger unit because the community of interest factors 'overlap almost completely.'" *Guide Dogs for the Blind*, 359 NLRB No.

151 (July 3, 2013), quoting *Blue Man Vegas, LLC v. NLRB*, 529 F.3d 417, 422 (D.C. Cir. 2008).

In determining whether employees share a community of interest, the Board looks at such factors as mutuality of interests in wages, hours and other working conditions; common supervision; degree of skill and common functions; frequency of contact and interchange; and functional integration. *Grace Industries, LLC*, 358 NLRB No. 62 (June 18, 2012), citing *Ore-Ida Foods, Inc.*, 313 NLRB 1016, 1019 (1994, enfd. mem. 66 F.3d 328 (7th Cir. 1995). The additional employees share an overwhelming community of interest only where there is no legitimate basis upon which to exclude them from the unit because the traditional community-of-interest factors overlap almost completely. *Northrop Grumman Shipbuilding, Inc.*, 357 NLRB No. 163, slip op at 3 (2011).

B. Application of Board Law to this Case

Under the guidelines set forth in *Specialty Healthcare*, the petitioned-for unit is an appropriate unit. In this regard, the LPNs and CNAs are a readily identifiable group of individuals who are primarily responsible for the day-to-day care of long-term residents. The record demonstrates that they work side-by-side at the Employer's facility, that both groups of employees are required to be licensed to perform their duties, that they share common supervision, and that they essentially work under the same conditions and utilize similar skills in performing their job duties, and their jobs are functionally integrated. See *Fraser Engineering Company*, Inc., 359 NLRB No. 80 (March 20, 2013)(petitioned-for unit appropriate where the record demonstrated, inter alia, common management, shared status as skilled tradesmen who must maintain special licenses or

certifications, similar wages and benefits, same company handbook and policies, employment in the same company, and some functional integration). I further find that the Employer has failed to establish the requisite "overwhelming" community of interest between the members of the petitioned-for unit and other employees necessary to overcome the presumption that the petitioned-for unit is appropriate. *Specialty Healthcare*, supra.

The Employer contends that, in addition to CNAs and LPNs, the following additional classifications must be included in the petitioned-for unit: Activities Aide, Adult Day Care employees, Environmental Aides, Clinical Care Coordinators, Unit Coordinators and Diet Technicians. I will analyze each classification in turn.

1. Activities Aides

The Employer employs four activities aides, two of whom are full-time, that work in the Employer's Activity Department which is located on the main floor of the skilled nursing facility. The two full-time activities aides are CNAs, while the two that are part-time are not.[16] Activities aides' primary responsibility is to coordinate and participate in activities for the residents.

Activity aides transport the residents to and from scheduled activities both on and off the premises. CNAs and LPNs may assist with the transport of residents, but do not attend the activity – that is solely the responsibility of the activity aides. Activities take place both on and off the premises. The activity aides who are CNAs attend the off-site activities, during which they may perform CNA duties such as toileting.[17] On

[16] According to the testimony of the Employer's human resources manager, the two full-time activities aides were "transitioned to being required to be CNAs so that if they go to outside activities they would be able to toilet and handle residents that go."

[17] The record fails to establish whether non-CNA activities aides attend off-site activities.

occasion, the activity aides who are CNAs assist Employer CNAs or LPNs in performing their duties and they take CNA shifts a couple of times a month to fill holes in the schedule. Activity aides are supervised by the activities director who reports to the Employer's DON.

I find that the record fails to demonstrate that activity aides in the petitioned-for unit share such an overwhelming community of interest with the members of the petitioned-for unit such that they must be included in the unit. The activity aides and LPNs/CNAs do not share common first-line or second-line supervision. There is no evidence of permanent interchange, and insignificant evidence of temporary interchange between the two groups. The two non-CAN activity aides cannot work as CNAs, and the two activity aides who are CNAs only pick up CNA shifts in addition to their scheduled activity aide work. There is no evidence that non-activity aide CNAs ever work as activity aides. Further, there is minimal functional integration between the two groups, as LPNs/CNAs merely assist with the transport of residents to activities, but do not attend the activities. Though there is testimony that CNA-licensed activity aides occasionally perform CNA functions, the Employer failed to provide specific evidence to indicate how often that occurs. *J&L Plate*, supra. Further, the other two activity aides do not perform these functions. While the record establishes that the activity aides work in close geographic proximity to the LPNs/CNAs, I find that factor fails to outweigh the substantial record evidence illustrating the lack of an overwhelming community of interest between the two groups, and therefore, find that the activity aides should not be included in the unit.

2. Adult Day Care Employees

The Employer operates an adult day care center, located within the skilled nursing facility, which provides day care for non-residents. Residents of the Employer do not attend the adult day care center. The Employer employs one LPN and two CNAs in its adult day care center. The employees perform CNA functions, including toileting and feeding the individuals at the day care center. The day care center holds joint activities (generally exercise classes) with the skilled nursing facility twice a week. Those events are run by both the day care center and activities department staffs. Day care center CNAs assist with the transportation of day care attendees to these events, but do not attend the events. If the day care center is unexpectedly closed, day care center employees may assist the Employer's staff. There is no record evidence indicating how often this occurs. Day care center staff is available to cover CNA and LPN shifts in the skilled nursing facility, though there is no record evidence to indicate how often this occurs. Adult day care employees are supervised by the director of adult day care who reports to the Employer's DON.

I find that the record fails to demonstrate that the adult day care aides share such an overwhelming community of interest with the members of the petitioned-for unit such that their inclusion in the unit is mandated. The adult day care aides do not share common first- or second-line supervision with petitioned-for CNAs and LPNs. There is insignificant evidence of temporary or permanent interchange. Adult day care center employees only work as CNAs or LPNs when the day care center in unexpectedly closed, and the record contains no evidence as to the frequency with which this occurs. When adult day care center employees take CNA or LPN shifts, they do so voluntarily,

in addition to their own shifts, and the Employer presented no evidence on how often this occurs. See *J&L Plate*, supra. Further, there is limited evidence of functional integration between the day care center employees and the CNAs and LPNs at the Employer. The day care center staff services a different population, and the record demonstrates that they have limited contact with the LPNs and CNAs in the petitioned-for unit. While the record establishes that the adult day care center employees work in close geographic proximity to the LPNs and CNAs, I find that this factor fails to outweigh the substantial record evidence illustrating the lack of an overwhelming community of interest between the two groups, and therefore find that the adult day care center employees should not be included in the unit.

3. Clinical Care Coordinators

The Employer employs two clinical care coordinators ("CCCs"), both of whom are LPNs. The CCCs work solely within the skilled nursing facility, and are primarily responsible for coordinating the care plans for each resident from admission to discharge. In that role, the CCCs assist the RN Supervisor with each resident's admission and discharge, coordinate consultations with health care professionals and attend care conferences.[18] CCCs inform LPNs of changes to each resident's care plan. The record demonstrates that once or twice a month, the CCCs may pass medications. One of the CCCs is adept at drawing blood, and may be asked to do so once or twice a week in lieu of contacting the phlebotomist at IDMH. CCCs may help with treatments

[18] The record states that the CCC and the MDS nurse coordinate the care plan and devise the plan for the resident's stay. The record makes no reference to the identity of the MDS nurse(s), or what other duties that position entails.

depending on their schedule.[19] CCCs have their own office within the skilled nursing facility, but spend time at the nurses' stations and interacting with residents. The record is silent as to the supervision of CCCs

I find that the record fails to demonstrate that CCCs share an overwhelming community with the CNAs and LPNs such that they should be included in the petitioned-for unit. As an initial matter, the record fails to establish that CCCs have common first-line supervision with the LPNs and CNAs. Further, the duties of the CCCs consist primarily of devising care plans for the residents and apprising LPNs of changes in the plans, while the LPNs and CNAs primarily engage in resident care duties. Although the record demonstrates that CCCs engage in some resident care duties, they do so sporadically, and there is no evidence that LPNs or CNAs in the petitioned-for unit ever act as CCCs on a temporary or permanent basis.[20] Further, CCCs have their own office and though they interact frequently with LPNs and CNAs, this evidence of interaction does not outweigh the significant difference in their duties and their working conditions. Accordingly, I find that the Employer has failed to demonstrate that the CCCs share such an overwhelming community of interest with the LPNs and CNAs that they must be included in the unit found appropriate herein.

4. Unit Coordinators

The Employer employs three unit coordinators, one assigned to each sub-unit, who are CNAs. The unit coordinators provide clerical support for each sub-unit at the Employer, including answering phones and answering questions from visitors. They

[19] The record does not disclose what types of treatments the CCCs might do, but says that they might do them on a weekly basis.

[20] To the extent that CCCs draw blood a couple of times a week, the record demonstrates that this is not an assigned duty but rather due to the special expertise of one particular CCC in this area who does so in order to obviate the need to call in a phlebotomist from IDMH.

perform their work at the nurse's station. One of the unit coordinators assists with passing meal trays and feeding residents on a daily basis. One of the other two unit coordinators may assist with serving residents in the dining room. Unit coordinators may take residents to off-site appointments. Unit coordinators, like the other CNAs, sometimes take residents to appointments at IDMH. The record is silent regarding how often unit coordinators engage in any other CNA activities. Unit coordinators are not expected to respond to resident need requests, but rather, are expected to remain at the nurse's station. Two of the unit coordinators sometimes voluntarily take weekend CNA shifts in addition to their regular hours. The record is silent regarding supervision of unit coordinators.

I find that the unit coordinators should not be included in the petitioned-for unit because the unit coordinators do not share overwhelming community of interest with the employees in the petitioned-for unit. The record fails to establish that unit coordinators and the LPNs/CNAs share common supervision. The record further fails to establish any evidence of meaningful interchange between unit coordinators and the employees in the petitioned-for unit. While one of the three unit coordinators passes trays and feeds residents, and the unit coordinators sometimes perform some CNA duties such as transporting residents, there is no evidence unit coordinators fill in for CNAs during the course of their regular workday, that they perform other traditional CNA resident-care duties, or that CNAs performs unit coordinator duties. Further, the primary duties of unit coordinators, providing clerical support to the nursing unit, differ substantially from those of LPNs and CNAs, and the record contains no evidence that they are required to be CNAs in order to perform these duties. As such, I find that unit coordinators do not

share such an overwhelming community of interest with the LPNs or CNAs that would require their inclusion in the unit.

5. Environmental Aides

The Employer employs two environmental aides, neither of whom are CNAs or LPNs. They do not provide any resident care, but provide support for the CNAs, and respond to requests for assistance from CNAs, LPNs or CCCs. In doing so, the environmental aides perform some functions also performed by CNAs, including making beds, transporting residents between units, and filling water pitchers. The environmental aides report to the LPN in charge.

I find that the environmental coordinators should not be included in the petitioned-for unit because the environmental aides do not share an overwhelming community of interest with the members of the petitioned-for unit. In this regard, the environmental aides are not licensed and, accordingly, are not permitted to perform any resident care duties, such as toileting or feeding the residents. In light of their different skill sets and job duties, and lack of certification or licensure, I find that the environmental aides do not share an overwhelming community of interest with either the CNAs or LPNs, and should be excluded from the unit.

6. Diet Technicians

The two diet technicians have an office in the Employer's facility and are involved in meal planning for IDMH patients and Employer residents. They spend a portion of their day in the office preparing meal plans and also speak with IDMH patients and Employer residents about their meals. Diet technicians spend time in the dining room ensuring that patient and resident meals are correct and they may help feed the

Employer's residents. One of the diet technicians works with Employer residents, while the other usually works with IDMH patients and adult day care attendees. The diet technician who primarily works with Employer residents has an associate's degree, though the record contains no evidence as to whether she is required to have such a degree. Record testimony indicates that diet technicians interact with CNAs, LPNs and clinical care coordinators, but there are no specific examples as to either the frequency or nature of these interactions. There is no record testimony regarding supervision of diet technicians.[21]

I find that the record fails to demonstrate that diet technicians should be included in the unit. There is no evidence that diet technicians share common supervision, or engage in either temporary or permanent interchange with the CNAs or LPNs. While the diet technicians assist with resident feedings, there is no evidence that they perform any other CNA or LPN functions, or that they are required to maintain any licensure or certification in order to perform their duties. As such, the diet technicians do not share an overwhelming community of interest with either the CNAs or LPNs, and should be excluded from the unit.

I also note that the Employer appears to assert the only appropriate unit of skilled nursing facility employees must include all of the employee classifications listed above, and that they all share an overwhelming community of interest with the employees in the petitioned for unit. Although some of the groups listed above share strong, but not overwhelming common interests with the CNAs and LPNs, it is apparent that others share very little common concerns with these groups. Thus, the Employer clearly failed

[21] According to the IDMH organizational chart, diet technicians do not report to anyone at the skilled nursing facility, though it is unclear to whom they report.

to demonstrate that, as a group, the employees it seeks to add share an overwhelming community of interest with the Employer's CNAs and LPNs. See *DTG Operations,* 357 NLRB No. 175 (Dec. 30, 2011).

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 employees 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 and regular part-time certified nursing assistants and licensed practical nurses employed by the Employer at its facility at 7571 State Route 54, Bath, New York; excluding registered nurses, activity aides, adult day care employees, clinical care coordinators, unit coordinators, environmental aides, diet technicians, managers, and all professional employees, guards, and supervisors as defined in the Act.

There are approximately 79 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 **December 6, 2014**. 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.nlrb.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.nlrb.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 Service*s, 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 on December 13, 2013. The request may be filed electronically through the Agency's

web site, www.nlrb.gov,[22] but may not be filed by facsimile.

DATED at Buffalo, New York, this 29th day of November 2013.

Paul J. Murphy, Acting Regional Director
National Labor Relations Board, Region 3
Niagara Center Building, Suite 630
130 South Elmwood Avenue
Buffalo, New York 14202-2465

[22] To file the request for review electronically, go to www.nlrb.gov and select the **E-Gov** tab. Then click on the **E-Filing** link on the menu. When the E-File page opens, go to the heading **Board/Office of the Executive Secretary** and click on the "File Documents" button under that heading. A page then appears describing the E-Filing terms. At the bottom of this page, check the box next to the statement indicating that the user has read and accepts the E-Filing terms and click the "Accept" button. Then complete the filing form with information such as the case name and number, attach the document containing the request for review, and click the Submit Form button. Guidance for E-filing is contained in the attachment supplied with the Regional Office's initial correspondence on this matter and is also located under "E-Gov" on the Board's web site, www.nlrb.gov.

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 3

FRED & HARRIETT TAYLOR HEALTH

Employer

and **Case 03-RC-115208**

1199 SEIU UNITED HEALTH CARE WORKERS EAST

Petitioner

AFFIDAVIT OF SERVICE OF: Decision and Direction of Election, dated November 29, 2013.

I, the undersigned employee of the National Labor Relations Board, being duly sworn, say that on November 29, 2013, I served the above-entitled document(s) by **regular mail** upon the following persons, addressed to them at the following addresses:

James Watson
Fred & Harriett Taylor Health
7571 New York 54
P.O. Box 350
Bath, NY 14810

Raymond J. Pascucci, Esq.
Bond, Schoeneck & King, LLP
110 W Fayette St
One Lincoln Center
Syracuse, NY 13202-1324

Rickey Elliott, Vice President-At-Large
1199 SEIU United Health Care Workers East
259 Monroe Avenue, Suite 220
Rochester, NY 14607

Mimi C. Satter , Esq.
Satter & Andrews, LLP
217 S Salina St., 6th Floor
Syracuse, NY 13202-1501

November 29, 2013
Date

T. Sanchez, Designated Agent of NLRB
Name

/s/T. Sanchez
Signature